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SOME PRINCIPLES OF BRIEF PSYCHOTHERAPY

BY WALTER BONIME, M. D.

In attempting to formulate principles of brief psychotherapy of the neuroses, it is important to recognize the problem essentially as one of recapitulating principles of *sound* psychotherapy. There is nothing basically new or special about this form of treatment. Its uniqueness resides in its disadvantages. Brevity in psychotherapy is a limitation. Rigidity is an ingredient of all neurotic problems and resistance always a factor impeding resolution. These elements cannot be overcome by strong, swift impact. As a matter of fact, these elements account to a large extent for the usual protractedness of effective work in this field. With limitations in time, the effectiveness of treatment will also be curtailed. In other words, brief psychotherapy is not streamlined; it is restricted psychotherapy. The problem of the brief psychotherapist is that of working according to the soundest psychotherapeutic principles in order to accomplish the greatest possible good under restricted conditions.

As in any psychotherapy of the neuroses, one of the chief goals is that of equipping the individual to deal independently with his life problems subsequent to treatment. One seeks more than the mere alleviation of acute distress. Achievement of such an objective always involves the development by the patient of some degree of insight into his personality structure. This may mean only a single aspect or several, and the depth of the insight may also vary. Revealing statements by the psychiatrist may often prove helpful. Usually, however, little more than an intellectual grasp can be attained by this means, plus some basis for guidance through the immediate distress. Life situations alone are often enlightening to the patient. There are, however, no technical shortcuts to true insight. Personalities are not integrated rapidly. If there is but a brief period in which to work, it is necessary to utilize it for the fullest possible resolution of the most crippling personality factor within reach.

Some principles can be formulated as a guide for achieving the greatest possible result while working under the handicaps of limited contact. This paper represents an attempt at such formulation and presents, as well, a case of traumatic war neurosis in which such principles were followed and in which psychotherapy

over a brief period brought fruitful results. The principles apply basically to any neurosis in any psychotherapeutic setting.

Case

This is a case of traumatic war neurosis in a 37-year-old chief steward (H. S.). He was treated during World War II at a merchant marine rehabilitation center. In May 1942, over two years before the writer first saw him, he underwent the chief traumatic experience associated with his manifest war neurosis. It occurred during the daytime in the Caribbean area. He was in the cold storage compartment of the ship when a torpedo struck the engine room, separated from him by a steel plate bulkhead or wall. The closed door was jammed by the buckling of the plates. The lights went out and the plates bulged and tore apart at the seam, shooting out the rivets like machine gun bullets, some of them hitting him painfully across the back. Jars of mayonnaise and pickles fell and covered the floor with a slippery mass of broken glass. Steam hissed from pipes, ammonia escaped from the freezing system, explosive fumes pervaded the space, and the propeller shaft, no longer turning against the resistance of the water, roared and vibrated at top speed.

One man knew, by chance, that the steward had gone below just before the torpedo hit. He ran down and pried open the door with a metal bar, releasing the steward in the midst of his terrified and frantic efforts to get out. The two men rushed to the deck and plunged, in life preservers, over the side of the rapidly sinking ship. They got to a raft which was still attached by rope. One man started, just as the ship was plunging, to cut the rope to keep the raft from being sucked under. The steward, not yet on the raft, grasped its slats and hung on, vaguely thinking that, if the rope were partially cut, it would snap from the tremendous dragging tension and that he would be carried back to the surface by the greater buoyancy of the raft, while, alone, he might sink deeper in the suction of the ship. He clung, while being dragged under some distance, and then the raft broke free from the ship and carried him and two or three others to the surface, where they climbed aboard.

There were 15 or 20 men in the water within a short distance of the raft, some only a few feet away. The steward had shipped with some of them for three years. Sharks swarmed among them.

There was no way of reaching these men. One after another, they were dragged under. Familiar faces, arms, voices, striving toward the raft with agony and fear, suddenly disappeared while the steward watched. He struck at the sharks with a boat hook to draw blood and distract them from the men—but to no avail. Those on the raft could do nothing to help their shipmates in the water. The steward saw eight go down. Of a crew of 65, only 20 survived, some having got off in lifeboats. These 20 drifted in the boats for 29 days, before rescue.

After returning to this country the steward began to have nightmares. These nightmares were always recapitulations of the torpedoing, in part or completely, with emphasis on the three outstanding aspects: (1) being trapped in the storeroom; (2) being sucked under; (3) being helpless on the raft while watching shipmates dragged under by sharks.

He was tense, often tremulous, could not stand confinement, ate poorly. At first he could get to sleep by taking a couple of shots of whisky, later he required more, still later he drank constantly, vainly seeking some kind of relaxation and rest. (He had never before had an alcoholic problem.) The process of repatriation took four months, and he returned to New York in mid-September. The following year was consumed by a long struggle for rehabilitation. It involved three separate admissions to a rest center, totaling six months, with shore duty in between, while maintaining contact with the rest center doctor. The year was also a stormy alcoholic one, but with some general improvement.

He finally shipped out against the advice of the doctor who had been carrying him nearly a year. He returned after a brief one and one-half month voyage, "feeling lousy."

He stayed ashore a month without drinking and shipped again for a three-month trip. This trip involved his being in the harbor of Bari, Italy, the night that port sustained a devastating bombing raid. Many ships were blown up and the next morning found the harbor littered with wreckage; protruding sunken ships; and floating bodies, many of them those of merchant seamen. This experience disturbed him deeply and brought back the old nightmares. He slept hardly at all, and often stayed up all night talking to different men in order to avoid the sleep that brought recurrence of the nightmares. He returned in March and shipped out three days later "because I wanted to see if I couldn't get rid of this thing myself."

This trip took him eventually to Normandy where his ship lay off the beach on D-Day and during the next three days and nights. There he saw landing barges blown up, bodies in the water. There were artillery fire, air attacks, floating mines. Even before this, however, the gunnery practice preparatory to D-Day had distressed him and revived the old nightmares. After D-Day, the events of the torpedoing began to come back during the day through various stimuli. He had begun to have dizzy spells and shaking spells. While on an England-to-France shuttle run after D-Day he developed such a bad shaking spell upon starting down a ladder that he fell to the deck below and woke up with a fractured skull in a Normandy hospital. After hospital ship and army hospitals, he was finally repatriated through the War Shipping Administration and eventually arrived at the rest center for convalescence.

This steward was first interviewed by the writer at the rest center nearly two and one-half years following the experience which had precipitated his traumatic war neurosis. He described it when asked to, without any histrionics, yet as though relating an experience of the past week. It was quite vivid to him since he was still reliving it in his nightmares. He was worried, depressed, tired. He could not sleep, except to wake up shortly with all the anxiety associated with a nightmare. He had suffered from "pain in the head" (which he distinguished from ordinary headache) since the skull fracture about two months earlier. He had occasional dizzy spells and occasional nausea and vomiting. There were no frank neurological signs. He had not touched liquor in a year. At the end of this first interview, he was given some encouragement regarding prospects for getting over his symptoms.

A few days later he was seen again, and a good deal of his past life was discussed. The significant facts can be briefly summed up. He was the oldest of three boys of a family which, while not impoverished, had to struggle for moderate comfort. The mother worked, and the father was a professional soldier. After World War I, the father was in the national guard and was able to live at home much of the time, where he maintained strict discipline. The patient, in spite of the discipline, worshipped his father. It was a great event for the patient when, in his early 'teens, he was admitted to the guard to drill under his father. When he was 17, his father's death came as a great blow. The home, however, was kept

intact. Four years later the three boys found their family spirit disrupted by the remarriage of their mother. The stepfather had nothing in common with the boys; and, entering the home, he came between them and their mother. All that the patient earned, nevertheless, went into the home until three years later when he married a girl whom he had been seeing for about two years. He was then 24 years old. About a year later, early in the depression, he started going to sea. Two children were born during the first three years. The steward was able, nevertheless, to maintain a fairly comfortable apartment for his family. On returning from a voyage after four years of marriage he found the apartment empty of family and furniture. He traced his wife and children and found that his wife had set up housekeeping with his furniture and even his clothes, and was living with another man. After a futile attempt at reconstruction of the marriage, he completely renounced her and all other women. He pursued a lonely life, sending most of his money to his mother and rising to the highest rating in his occupation at sea, that of chief steward. At the end of seven barren years the torpedoing occurred.

After this general exposition of the significant events in his life, the conditions were set for analytic interpretation, for a direct attack upon the problem. He was told that there appeared to be a relationship between past events and the traumatic force of the torpedoing experience. It was suggested to the patient that the nightmares and all of the features of his illness since that war experience did *not* represent symptoms of an emotional, a psychiatric, sickness that started *during* the war and which seemed too severe to overcome. Rather, it looked as if certain aspects of his torpedoing experience were devastating to him because they represented in an intensified fashion what had been happening to him all his life. Everything of value to him had at various stages of his life been sucked under, dragged under and lost. His father had been dragged away from him by death. The home life that survived had been torn from him by his mother's remarriage. His own family and wife had, in turn, been as ruthlessly sucked under.

In all these situations he had had to sit by helplessly. He had felt as helpless at the side of his dying father as he had felt watching his shipmates dragged under by sharks. He was unable to save the home spirit when his mother remarried an uncongenial and calculating stranger. He was helpless to reconstitute his fam-

ily when his wife deserted him. In all these situations in which the virtual foundations of his existence were destroyed, the outstanding feelings were a sense of imminent annihilation and a profound sense of helplessness. He was himself trapped and dragged down; and he saw all that was precious to him being destroyed as he sat by, inadequate and unable to rescue anything.

It was pointed out that the torpedo experience was one that would have been difficult for almost anybody to endure. It was emphasized, however, that its effects did not represent a sickness acquired during the war but were due largely to the symbolic significance they had for difficulties he had struggled with all his life. He was told that the solution of his difficulties was a problem upon which *he and the doctor would collaborate.* Optimism was expressed over the fact that a clearer orientation had been formulated.

That night he had a dream; and, in it for the first time, his father appeared. Pressure of medical work imposed a delay of two days before the next therapeutic meeting. During this time he was preoccupied by the dream and the fact of his father's appearance in it. He was eager to discuss it with the doctor. When they finally met, the therapist apologized for the delay. Following is the dream that the patient related. (This and the subsequent dreams are reproduced as written down by the man.)

Dream No. 1. "I was on a ship, sitting at a desk in the fo'c'sle. I was alone. The ship was sinking. There had been no torpedoing or anything like that. The ship was just sinking. I sat there and sank with the ship—no fear or any such feeling. Finally the ship settled on the bottom and I got up, opened the door and walked out. I walked through a dark tunnel. Suddenly there was a door and I opened it and walked into a room. There I saw my father, sitting behind a desk with a big book in front of him. He looked up at me and said sort of sternly, 'You can't stay here. Go and make something of yourself; you can't stay here.' Suddenly I was in a lifeboat. I was alone and felt lost and depressed. I looked up and could see land—a city in the distance. There was a man in uniform standing on the beach waving for me to come over. I couldn't make out who he was, but he seemed familiar. I got up and walked out of the lifeboat and across the water to where the man had been on the shore. When I reached the shore he wasn't there. There were crowds of people, all strangers. I looked

around to find this man and wanted to find out from the people going by where he was. I was sure that if I could find him he'd lead me to a certain place in the city where I would stay and everything would be fine. I kept looking everywhere for him and then suddenly woke up. I was sweating all over. My heart was beating fast, and I was terribly scared."

He was asked if during the past year or two he had sometimes felt very depressed, felt like chucking the whole business. He replied, "Yes, that's just it. During the last two months especially I have been terribly depressed. I've often wished I'd gone down with the ship."

The following interpretation was given: "Going down with the ship is what you would like to have been able to do to solve your problem or, rather, get rid of it. Your life has become very threatening, full of fear of having anything of value sucked under, torpedoed, devoured by sharks. Sinking with the ship represents the same sort of thing you sought with alcohol. You meet your father who represents the dead whom you wish to join. He, however, says, 'You can't stay here, go and make something of your life.' This is your own recognition that death is no solution. It also represents a real feeling of yours, of wanting to get something out of life. Such a decision, however, leaves you again alone and literally at sea—as you were in the lifeboat. Having made a positive approach to your problems, however, your dream goes on and presents life to you again—the busy city, filled with people. Someone is encouraging you to join in life again. [Associations are of a previous doctor, also another WSA official who helped him get a job, and still an uncertainty of identity persisted. The face kept fading and coming into focus again in a new form, never quite recognizable. Possibilities suggested to him included the new doctor, social workers, and nurses.] Recognizing that to find a person who would lead you to a certain place where all would go well is an impossibility, represents a recognition of reality in your dream. No one can really lead you by the hand to a life without struggle or disappointment. The important thing in your dream is your turning toward life. The prospect, however, of venturing again *alone* is too much and you awake in great fear, the kind of fear associated with the other dreams where you are being annihilated, the fear that makes you turn away from life. It is as though annihilation, loss, helplessness, are the only prospects before you if you face

life. Your dream shows, however, a real sign of progress in you, for it is still *your* feeling in the dream, one of hope and of desire to face life and to take part in it."

That night he had another dream which puzzled him and which he was eager to discuss.

Dream No. 2. "You [doctor] and Dad are in a big office sitting together behind a very large desk. You are just as distinct and clear in features and dress as if I were to talk to you now, person to person. Dad's features were clear, but I can't seem to remember how he was dressed. I seemed to have some job, or something that I was ordered to do, and I did not think that I was doing it properly. Dad did not talk to me directly, did not even say hello when I came in the office, but you and he seemed to confer together and you explained to me that you yourself and whoever I worked for or had to do something for were more than satisfied with the way I was conducting this business. I seemed to feel that I had failed to do properly in every detail whatever I was supposed to do and that I had failed somewhere and that I wanted to go somewhere that I would be all alone. I seemed to be disgusted with myself and ashamed because whatever I was supposed to do seemed so simple. You talked to me directly, Doctor, and explained to me that you and (others?) were entirely satisfied with the way I was conducting this job. You explained to me that as far as I had gone I had done well and that to let someone else in the mission or job would fail and that you and (others?) depended on me to finish whatever it was I was supposed to be doing. You put your arm across my shoulder and walked to the door with me as I left the office. I walked down a long, long corridor and it seemed that I was not pinned, or held down, or that a great weight or some very great trouble had been taken away from me. It is hard to express but in some way I felt free. I woke up and I was sitting up in bed, and that is how I felt when I came to myself and that is exactly how I have felt since I arose this morning and at the present time. I feel better way deep inside today than I have in the past ten years. The way I feel is hard to explain only that I feel at ease and that there are people who give a damn and that I do what a man is supposed to do."

He was willing this time to attempt to interpret by himself and offered the following: "I know you're helping me and I go in to see

you. But no matter how you help me or what I do, there's something holding me back."

The following additional interpretation was offered him: "That something is a lack of confidence in self, it's a feeling of having no value as a human being, of not counting for anything. Both your father and I represent people who feel you are a decent and capable individual and can carry your own weight in life. Your feeling of not letting anyone in to help you on the job indicates your further acceptance of reality as it came out in the previous dream where the fellow on the shore who called you back to life disappeared when you reached the shore, signifying that you can get something out of life only by carrying your own weight and can't expect to have others make the way easy. This time you are not frightened by the prospect as you were in the earlier dream. The prospect of a self-confident life of your own frees you of the burden of fears, the burden of helplessness."

That night there was a dance. In reporting it he said, "I sat and watched the other fellows having a good time. I felt why shouldn't I have these things, too? I got up and danced and joked and really enjoyed myself."

A night later he had another dream.

Dream No. 3. "I do not remember if the ship had been hit by a torpedo, do not even see a ship in this dream. I am on a raft; there are other men with me but they don't seem to mean anything to me and it doesn't seem to mean anything to me if they are there or not. I am standing on the raft and what it is in my hand I can't make clear, but I am killing sharks left and right and it doesn't seem that I am doing this because of what they are or what they have done. It seems to be that there is some pent-up hatred inside of me that I am venting on them. They seem to be a hindrance to me and are in my way of a figure who is beckoning to me from shore, who seems to be pleased with what I am doing to try to get to him. When my way is clear and I am almost to this officer, I woke up. My heart was pounding and I was soaking wet with perspiration. But I felt good and did not seem to have a [discouraged?] feeling that I had in preceding dreams.'

It was suggested that the dream represented his fury at those influences which had always resulted in his loss of the good things in life. His striking out at the sharks represented a real self-assertion, a determination to get past the obstacles and get posi-

tive satisfactions, seek a real life of his own. Out of this discussion developed, not a repetition of the major misfortunes already recounted, but a series of situations in which he was submissive, self-effacing, exploited without complaints or revolt on his part. He said, "I've always sat back and let people walk all over me. I always felt it was better to keep things peaceful." He told of how it used to mean so much to him as a child to visit his aunt in the country and how it was always his brother who was sent by the parents to spend summer vacations there while he would work, sometimes being a milkman's helper at one dollar a week. Even then he couldn't play ball with the boys on Sundays.

He described how he had sat at the bedside as his father died. "Five minutes before father died he pulled me to him and said, 'For God's sake, be good. Do the best you can.'" Then the patient added, "I've tried to be nice ever since. It seems I've done myself harm through it. The nicer I am to anybody, I expect him to be the same and goddam if I don't get a kick in the back." It was indicated to him that "being nice" often represented a failure to stand up for his rights. His generosity, good will and fairness were not overlooked, and emphasis was placed in this context on his failure to assert himself. He spoke of the good time he had had at the dance and concluded the interview with: "After talking with you this week, I'm not going to be stepped on any more, I know it."

The succeeding night he dreamed again. As with the other dreams he followed the request to write it out. The following was submitted:

Dream No. 4. "This dream last night started with my being on a ship. I do not remember getting on or where. I am on this ship and we are under way at sea. I am sitting at my desk in my quarters at my books. I close the book I am writing in, leave my quarters, walk out on deck, and jump overboard. I have absolutely no sensation of sinking or any feeling of going under, everything just turned black. How soon after this I woke up I do not know, but when I did I remember this very clearly and I could not sleep for the rest of the night."

A brief interpretation was offered. It was suggested that the contemplation of a complete change of personality all at once, or even the effort to initiate self-assertion, had become overwhelming.

He had reverted to the former method of solution, running away. He replied, "I knew the dream meant an easy way out."

The next night there was another dance, he had a turn with every girl there, and thoroughly enjoyed himself. He was discharged soon afterward and received a two-month temporary release from maritime service. In spite of financial and other practical difficulties, he kept a positive view of things, and finally obtained a job as instructor in cooking at a maritime school.

In the course of the routine physical examination for this appointment, however, the chest x-ray revealed an entirely unsuspected minimal pulmonary tuberculosis which disqualified him for that or any other satisfactory position in his profession. He obtained part-time work in a seamen's home on the waterfront and struggled for five months with barely enough money for food and lodging. Frequently during this long period of struggling the nightmares returned. During the last few weeks his discouragement made him no longer able to refuse the constant invitation to drink. He was seen by the writer a few times shortly after discharge, was helped in practical arrangements and by encouragement. At the end of five months he was seen again and an x-ray was ordered which showed sufficient pulmonary pathology to have him hospitalized. It is felt that there had been a good chance of a favorable outcome for this man if tuberculosis had not prevented him from capitalizing on the positive forces which had clearly been mobilized in him when he was discharged from the rest center. The case is presented because of the richness of the clinical material, because it illustrates definite forward movement during short-term therapy, and because the clinical experience embodies the therapeutic principles herein discussed.

Discussion

One important principle of brief psychotherapy illustrated in the handling of the foregoing, is that of making a careful evaluation of long-established personality trends as opposed to focusing upon precipitating circumstances (Principle 5, in the following). This is regarded by the writer as crucial in dealing with the war neuroses in general. The tendency in handling war neuroses has been that of relating immediate reaction too much to the war situations themselves. The situational factors of war are intense and dramatic, and tend to preoccupy the therapist as well as the patient.

The author's experience with merchant seamen suffering from war neuroses has impressed upon him that the war neuroses are not circumscribed in time or form. Rather, even with traumatic war neuroses, the situational factors engendered by war serve essentially as precipitating factors, operating in the same way as other traumata under civilian circumstances. Their dynamic effects develop in terms of previously existing personality disturbances. Anyone undergoing the series of traumatic experiences of this steward would certainly be unstabilized. It was necessary, nevertheless, to evaluate his reactions to these experiences in terms of long-established personality difficulties over a broad range of experience in order to attain a substantial therapeutic result. As an isolated set of experiences these traumatic episodes of war appeared to the steward to have disabled him permanently, as irrevocably as though he had lost a limb. The war traumata were placed, however, in their proper perspective as involving problems that had existed long before. They became part of something that had always been disturbing. They represented the sort of thing this man had been wanting to overcome all his life. They involved problems for which he could, perhaps for the first time, have hope of successful solution.

Formulation of Principles

Following is offered a formulation of some principles of brief psychotherapy. The term "brief psychotherapy" implies a contrast with long-term psychotherapy. The formulation given here is stated largely in terms of this implied comparison.

Unity of basic principles is emphasized as underlying the two types of therapy. Brief and long-term methods equally involve these principles, which represent the fundamental demands of *any sound* psychotherapy. Divergences arise from the special demands of psychotherapeutic situations in which brevity of contact is a prominent factor. Such divergences are not the basis of new or exclusive psychotherapeutic principles. The factor of brief contact, however, justifies a restatement of general psychotherapeutic principles with modifications where they are demanded by the special situation. The psychiatrist practising brief psychotherapy must:

1. *Take a much more active role* than in long-term therapy. Greater activity is particularly needed in interpretation. This is

so even though this factor runs counter to the growth of insight on a deeper plane. Deeper insight accompanies the *prolonged* struggle by the patient in long-term therapy for understanding of himself. There is, however, not enough time in brief psychotherapy for the patient to develop the necessary sense of responsibility, the skill, confidence, and desire, which are prerequisites to his working out his difficulties on a plane of deep insight. Greater activity on the part of the doctor also applies in other spheres. The therapist must give more of himself in terms of friendliness, moral support, encouragement. His active assistance in practical arrangements and his direct advice are often needed. These elements are recommended in brief psychotherapy somewhat in the spirit of pointing out a necessary evil. This evil consists of their fostering dependence and counteracting deeper personality integration. They are deterrents to success when relied upon in longer-term psychotherapy. In brief contacts, which are often emergency situations, these forms of greater activity provide the kind of support that allows the individual to put into motion the positive elements of his personality. This increased external support is something like a blood transfusion in a surgical emergency. It allows the reparative, constructive forces of the body to operate. Blood transfusions, however, cannot be relied upon on a long-term basis to take the place of exercise, rest and a wholesome diet. Because of the briefness of psychotherapy, then, the doctor is much more active in interpretation and general supportive measures.

2. *Establish the fact that the therapist is a collaborator.* The patient often regards him as omniscient or omnipotent. Basically, the therapist has two chief qualifications for helping the patient. The first is his experience and training. The second is his relative freedom from emotional involvement in the patient's specific problems, a condition which leaves the therapist's observation and judgment relatively clearer. Establishing the therapist as a man who is a qualified collaborator in the working out of emotional disturbances is an orientation which gives the patient greater self-respect and self-reliance. It also engages him more fully in working out his own problems. He, too, becomes more of a collaborator. He is less the helpless subject, less the mere critic or admirer of the therapist. Furthermore, looking upon the doctor as a collaborator is realistic; the therapist does not know all the answers and requires the fullest co-operation of the patient to be most effective.

3. *Seek the most pertinent and accessible personality difficulty and clarify it.* While related aspects of the problems may perhaps be fruitfully dealt with, it is important to *avoid scattered interpretation.* In the bewilderment accompanying all neuroses, the patient is glad to recognize something real about himself by which to get his bearings. It is important to keep this in focus. Multiplicity of interpretation may produce a current sense of relief, but leaves the patient without direction for the development of further insight. Direction is what he needs desperately.

4. *Avoid interpretative exhibitionism.* It is most important for the patient to sense a sympathetic concern over his difficulties. The atmosphere of the interview is much more conducive to a productive issue, even when the therapist is stumped, if the patient feels his welfare is at stake rather than the therapist's professional prestige. It is important to remember that often little and sometimes nothing can be accomplished in a brief period. It is sometimes judicious as well as kind not to offer an interpretation, even though it may be valid. A neurotic problem represents, not so much a challenge for the right answer, as a cry for help. A tired swimmer feeling himself near to drowning might find greater moral support in a frank, "I can't get to you right away," than from a casual, "What you need is a life jacket."

5. *Carefully evaluate situational factors—by themselves and in relation to trends.* The patient tends to make circumstances the basis of rationalizations or as he calls them when he has insight, "alibis." The fact, however, that a patient uses situational factors as alibis does not entirely cancel their significance. To determine their true significance is part of the job of understanding the total problem and is indispensable in determining action. The patient's rationalization regarding situational factors is used both to avoid responsibility for actions and attitudes and to avoid the imperative to change that comes with insight.

It is important early to raise the question of how far an individual's personality difficulties are the basis of his condition and to what extent hardship is due primarily to situational factors. For example: A man who develops a traumatic war neurosis following a torpedoing may have been quite understandably shaken by the catastrophic nature of the disaster. Equally as disturbing, however, may have been the fact that he had to shout for help, when his personality structure had as a cardinal trend the need to feel

self-sufficient at all times. Reassurance or measures, such as catharsis, taken to eradicate a devastating memory, might be palliative but would have little integrating influence. Some consideration of his need for self-sufficiency on the other hand would give the man a constructive approach to a concrete personality problem. At the same time he would evaluate, in the light of this insight, his reaction to the torpedoing.

6. *Recognize and seek to uncover the basically low self-esteem of all neurotics.* This element of the neurotic personality structure is manifested in many subtle ways, frequently in terms of compensatory mechanisms, such as vanity, hostility, contempt, pugnaciousness, perfectionism. Many patients are totally unaware of their low self-regard; even those who recognize that they feel inferior are seldom aware of how deep the feeling goes and they are never aware of a great variety of ways in which this is expressed. They can usually be shown this uncertainty of their own value in the dependence they have on the opinions of others and in recognition of the ways they strive for approval and to ward off disapproval. They recognize themselves readily in simple figures of speech. For example: (a) Their self-esteem varies in response to outside opinion as a thermometer which rises in an atmosphere of warmth and drops when the surroundings are cool. (b) The neurotic knows that a commodity like wheat does not change in quality with the fluctuating market quotations. Yet, in contrast, as the "quotations" on a neurotic himself rise and fall, he feels almost as if his substance mutates toward the acceptable or depreciates into disposable waste.

A clearer understanding of this low self-esteem makes more intelligible to the patient many of the distortions of interpersonal relationships, compensatory mechanisms, depressions, and psychosomatic letdowns from which he suffers. One of the most important aspects of the gaining of insight into one's low self-esteem is that it lays the groundwork upon which a person can develop a realistic self-respect. Formalistically, this leads directly to another principle of brief psychotherapy:

7. *Analyze clearly the good qualities of the individual.* The neurotic has a very unreal picture of himself. It is usually a derogatory distortion or a compensatory idealization or a combination of the two. Basically he doubts his own value, and either is

not aware of or cannot call his own the positive aspects of his personality. While in general medicine a patient approaches a doctor with the query, "What's wrong with me?" the psychiatric sufferer needs desperately to know what's right about him, too. When he has worked through to some understanding of distorting tendencies that exist in his self-appraisal, he is in a fair position to grasp what he really is. In a more realistic frame of reference, he is prepared to accept, along with his actual defects, his actual assets.

8. *Choose the patient who accepts you.* Whom does one choose for real therapy from among the numerous neurotics who appear in the psychiatrist's office? Youth, good physical status, surmountability of environmental difficulties, these are all favorable prognostic factors. Basically, however, the patient with whom you can go farthest is the one who seeks to understand your language, who looks for your collaboration, who joins in the job you are trying to accomplish. Often it is the therapist's job to discern the signs of such acceptance beneath a resistant or apparently unready exterior. When an individual shows desire or willingness for further work by whatever sign, and even in spite of conventionally unfavorable prognosis, he has designated himself as the therapist's choice of patient.

9. *Refuse to rely on catharsis.* It is necessary in any psychotherapy, brief or protracted, for the therapist to participate every moment. It is true that participation may mean no more than attentive listening. There is a tendency, however, for psychiatrists to take a complacent satisfaction in just listening. Listening is a very large part of the practice of psychiatry. There is less time for it in brief psychotherapy. What the psychiatrist hears may at times lead him to avoid any attempt at treatment. Even that, however, represents an active choice. One must listen well to make such a choice, and must be willing to accept a psychiatric defeat. Most of the time, scrupulous attention leads to perception of personality patterns in scattered analogies, in inflections, punctuations, and style. Clues of this sort are stimuli to further questions or expressed observations, or become mere mental notes for future reference. In brief psychotherapy, because of the limitation of time, greater activity is required on the part of the doctor to keep to the point, to find the point, or to lead to the point. One cannot rely on the slow freight of free association.

Nevertheless, the needed vigilant attention is sometimes absent from an interview. The psychiatrist may listen with eagerness or forbearance to the voluble patient. With kindly and pertinent promptings he may elicit painful intimacies from the reticent. And the patient may gain a significant comfort from feeling safe and expressing himself. The psychiatrist, however, who contents himself with the knowledge that catharsis is beneficial and strives for no more, loses an opportunity to enrich his experience and to increase his skill. What is more, he has abandoned his patient.

Summary

The case reported in this paper may be reviewed briefly from the aspect of the principles of brief psychotherapy that were involved. Certainly there was considerable activity on the part of the therapist. A good deal of interpretation was offered directly. Relatively little time was devoted to free association. A friendly, serious, contemplative atmosphere prevailed. Much encouragement was given. Practical assistance was given in making plans for the period following discharge. The positive, admirable aspects of the personality were clearly delineated. As far as choice of patient is concerned, this man received more than the ordinary allotment of time because of his receptivity, co-operativeness and productivity. Productivity was in terms of psychic material and also in terms of his noticeable progress, in his increasing self-esteem, and his deepening social relationships, as well as his approach to the future. The atmosphere of collaboration was early established and the man's own activity was high in spite of the energetic participation of the therapist. Only a few aspects of the total problem were worked on. Such factors as hostility and cruelty were not reached. Low self-esteem, with its concomitant dependence on others for approval, the forfeiture of one's own rights, and the feeling of helplessness were especially emphasized. Interpretation was not scattered over the whole wealth of offered material, and what was given by the therapist was submitted as impressions or "hunches." The patient's painful unhappiness was a source of real and overt concern. He was never left in awe by the exhibition of another's insight, but rather given a hand and kept preoccupied in the development of his own.

These principles of brief psychotherapy do not attempt to cover the whole field. They were formulated in the course of three years of experience in practising brief psychotherapy with psychiatric war casualties from the merchant marine. It is felt that these formulations would apply equally to brief psychotherapy in any setting.

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FLUCTUATION OF DANISH PSYCHIATRIC ADMISSION RATES IN WORLD WAR II: INITIAL DECREASE AND SUBSEQUENT INCREASE

(*Trends in Psychiatric Hospital Admissions* 1939-1948)

BY B. B. SVENDSEN, M. D.

From the times of Pinel and Esquirol to the present, general interest in the problems of psychiatric statistics has been considerable in most of the civilized countries, although some of the methods and particular topics of concern may have varied. One of the reasons for this interest can be traced to the long-known fact that admissions to mental hospitals may show rather significant variations within any given period of time, thus revealing certain important trends in certifiable morbidity rates.

According to Deutsch, Pliny Earle was the first to stress the need of careful psychiatric statistics more than a hundred years ago. The formulation of such a discriminative approach was an essential part of a plan to replace the then customary "cure" statistics, published by mental hospitals from a strictly competitive point of view and, therefore, often grossly unreliable. The main objective of this new system was, of course, to raise psychiatric statistics to the level of a scientific discipline.

Although the causes of significant fluctuations in admissions to mental hospitals have been subjected to various comprehensive investigations in the United States, they have received relatively little attention in European psychiatry. Of the major American studies, those of Dayton; Landis and Page; Malzberg; and Pollock are particularly worth mentioning. In the Danish literature, statistical problems of this kind have been discussed particularly by Selmer and Hallager.

Causes of Fluctuations in Admission Rates

It is probably correct to say that there are valid reasons for questioning the value of many medical statistics. At least, it is highly unlikely that any of the major enigmas of clinical medicine will ever be solved by statistics, in spite of the undeniable usefulness of "quantitative medicine" in the understanding of the social aspects of disease.

However, we do have statistics, and some system of recording will always be necessary as long as we have patients in our hospitals. Obviously, therefore, significant data accruing in these records should be utilized, especially data which have a bearing on general variations in morbidity.

One essential source of information supplied by hospital records is the registration of admissions. Therefore, a very important question to be raised is: *Why do admissions fluctuate?*

In psychiatry as well as in epidemiology, there has been a tendency to distinguish three types of morbidity fluctuations:

1. *Seasonal* fluctuations, which tend to recur every year;
2. *Short-range* variations, which express themselves within a period of a few years; and
3. *Long-range* variations, which are fluctuations expressible only over a period of many years.

The fluctuations to be discussed in this report are classifiable largely as short-range variations.

The factors responsible for such fluctuations in admissions may be divided into (1) *nosocomial* factors, (2) factors affecting *"the threshold of hospitalization"* (called *threshold factors* hereafter), and (3) factors which lead to *quantitative differences* in the number of mentally ill persons.

Nosocomial factors refer to institutional conditions (especially a shortage of hospital beds) which make the number of admissions different from what would be the case, if hospital facilities were optimal. For instance, if there is a shortage of beds because of the prolonged retention of many chronic cases, a decrease in the number of admissions does not necessarily reflect a decrease in morbidity. With respect to mental hospitals, a common nosocomial factor which tends to obscure morbidity fluctuations is constituted by significant differences in the number of transferals from one institution to another.

Threshold factors are indicative of circumstances which change the rates of mental patients admitted to hospitals. As a rule, only a certain fraction of psychiatric cases are serious enough to require hospitalization. If this fraction remains constant, an increase in the number of admissions is an indication of increased morbidity, other factors being equal. However, any change in this threshold merely simulates a change in general morbidity rates. Although it may sometimes be difficult to keep these two

sets of modifying factors strictly apart, it should be realized that they are both expedient in general and practically indispensable in an analysis of morbidity fluctuations based on hospital statistics. Unfortunately, there are still many workers in the field of psychiatric statistics, who fail to take these factors into account.

Concealment of True Morbidity Fluctuations

As an illustration of the effect of nosocomial factors, the number of admissions to Danish mental hospitals is shown in Figure 1 for the periods of 1895-1920 and 1920-1948. Those periods, during which the number of admissions was determined largely by this type of factor, are indicated by a dotted line. It is interesting to note that nosocomial factors lacked significance only during a very brief period, from 1940 to 1945.

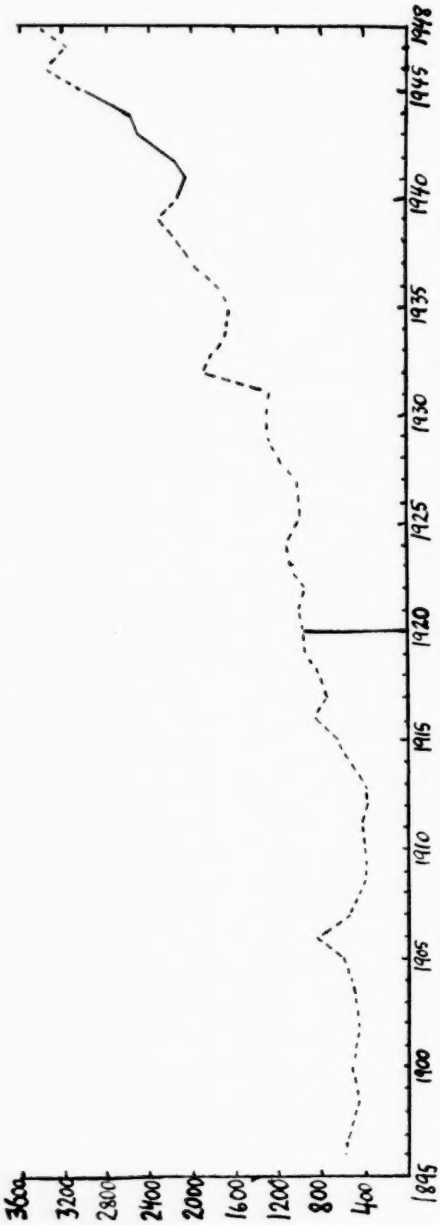
In years in which nosocomial factors require the organization of waiting lists because of a shortage of hospital beds, the number of admissions has been shown by Selmer, Hallager, and Landis and Page to be determined by the number of discharges and deaths and by the supply of new beds. Accordingly, the peaks of the curves, which show the rise of Danish admission rates, disclose a striking correspondence with the expansion of hospital capacities and thus reflect the construction history of mental hospitals in Denmark.

The significance of threshold factors is particularly obvious in an analysis of long-term trends, which have always been rising in modern times. The first problem to be considered in such a study is whether an apparently observed increase in morbidity is real or caused by increased hospitalization.

Other factors, which may mask true morbidity fluctuations, may consist of changes in the size of a given population, in age distribution, or in the representation of the two sexes (one of which may be more vulnerable than the other). It is evident that an analysis of basic morbidity fluctuations would be of little scientific value, unless these general population factors were fully evaluated.

Another approach to the differentiation of real and apparent morbidity fluctuations has been suggested by Dahl. According to this investigator, suicidal patients cannot be rejected and, therefore, are independent of the usual nosocomial and threshold factors. If other types of mental disorder tend to fluctuate in a similar manner, the fluctuations may be expected to reflect the same

Figure 1. Admissions to Danish Mental Hospitals



Annual admissions to Danish mental hospitals, expressed in absolute figures. Emphasis is placed on the year 1920 because of an increase in population caused by the reunion of Denmark with South Jutland (North Schleswig) which had belonged to Germany from 1864 to 1920.

set of factors that is responsible for variations in attempted suicide.

Crude Short-Term Fluctuations, 1939-1948

In the decade 1939-1948, the psychiatric clinics available in Denmark had a total of approximately 108,000 new patients. To use this fact for an analysis of short-term variations in morbidity, it is necessary to consider the distribution of psychiatric institutions in the entire country (Figure 2).

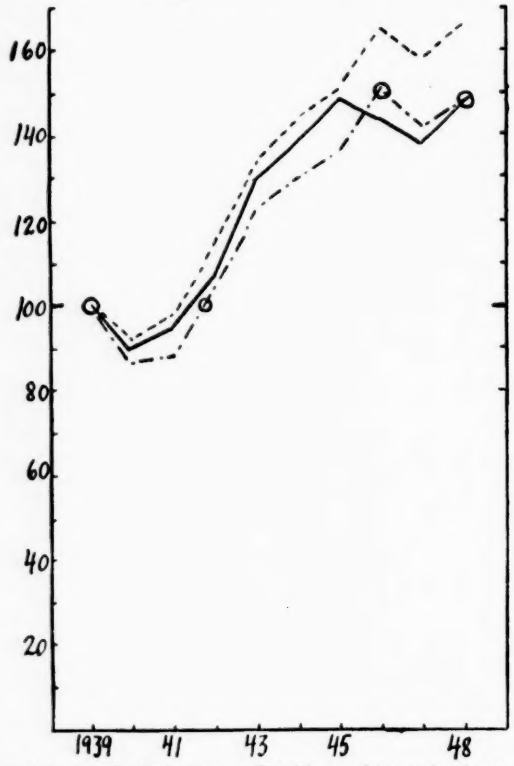
Figure 2. Distribution of Danish Mental Hospitals

The country's total population (4,000,000) is divided by the Great Belt into two approximately equal sections. The population west of the Belt is served by five state mental hospitals which admit their patients directly. The capital, Copenhagen, is in the eastern area and has four psychiatric clinics for its total popula-

tion (1,000,000). In the remaining area east of the Belt, there are two municipal hospitals which receive patients only through the clinics, and two state hospitals, which take both direct admissions and some transferals from the capital. The only private institution in existence (Filadelfia) has about 150 beds. Altogether, ordinary psychiatric institutions in Denmark (including farm colonies and other branch institutions) have a total capacity of 10,000 beds. In addition, there are special institutions for epileptic and mentally defective patients.

The trends indicated by the crude admission rates for the period 1939-1948 (Health Department Reports) are shown in Figure 3

Figure 3. Fluctuation of Crude Admission Rates 1939-1948



Index values for annual admissions to Danish psychiatric institutions in the period 1939-1948, with the 1939 figures rated as 100: "crude" figures (———); "corrected" figures for all psychiatric institutions (- - - -); admissions to psychiatric institutions with available admission figures for the entire period 1939-1948 (— — — —).

with the 1939 rate used as an index, fixed at 100. The fluctuations observed reveal an initial decrease, which came to a stop in 1942, a marked increase up to 1945-1946, and a fairly even level toward the end of the decade. These trends are indicated most clearly by the admissions to psychiatric clinics and to those state hospitals admitting patients directly. Therefore, the present analysis will be limited to these two groups of institutions.

With respect to the operation of *nosocomial* factors within the decade, it may be noted that the period 1940-1944 was distinguished by a rather unusual feature in the history of Danish psychiatry: Neither the state hospitals nor two of the clinics in Copenhagen had waiting lists, although they may have been affected by a sometimes uncomfortable tendency to overcrowding. During the second half of the decade, however, all the hospitals and clinics had waiting lists. One may say, therefore, that there may have been certain modifications of admission rates because of nosocomial factors during the period, although it is apparent that the extent of these modifications cannot have been very pronounced.

The factors which may have affected the *threshold value* are more difficult to evaluate than the nosocomial ones. The main question is whether the decrease observed in admissions during the first part of the decade may have been due only to a rise in the threshold of hospitalization on account of the German occupation Although the apparent decrease in morbidity was also seen in general hospitals, out-patient departments and private practice, it does not seem very plausible that the morbidity itself was reduced by the operation of some mysterious agent. Instead, it may be assumed that even in the event of illness, many people were induced by feelings of solidarity to stay at home at a time of danger. It is probable, therefore, that the decline in admissions during this period was the result of a raised threshold of hospitalization, partly at least, a universal reluctance to seek medical aid.

It is interesting, however, that the decrease in admissions to psychiatric clinics was almost twice as marked as, and much more prolonged than, that observed in the other medical departments. In fact, the decline in psychiatric admissions extended not only to mild cases, but also to relatively severe ones including cases of attempted suicide. There is reason to believe, therefore, that a relatively high threshold of hospitalization was associated with some real decrease in morbidity during the period.

To determine whether the subsequent increase in admissions (toward the end of the occupation) may have been caused by a lowered threshold factor, it may be borne in mind that the hospitalization rate during the past 50 years has risen for all diseases including mental disorders. It may still be questionable whether there has been a disproportional increase in the incidence of psychoses during this period. It is beyond doubt, however, that both an absolute and a relative increase took place because of increases in population and in its average age.

In mental hospitals, the rate of admissions per 100,000 persons was practically quadrupled from 17 in 1870 to 67 in 1940. Evidently, a certain proportion of this increase was due to a lowered threshold, that is, to an increased tendency to hospitalize relatively mild mental cases. In addition, however, there must have been some real increase in morbidity, especially as the expansion of hospital capacity was always apt to lag behind demand for admission during the period. The assumption of a real increase appears justified, if one compares the line illustrating the average increases in admissions during the period 1920-1939 and the extension (in Figure 1) of this line beyond 1939. The extended line remains below the average line for the years 1940-1942, is slightly above it for 1943 and 1944 and far above during the period 1945-1948. In view of the increase observed in the frequency of suicidal attempts during the same period, it is unlikely that the increased admission rate was exclusively due to a lowered threshold value.

Statistically Corrected Morbidity Fluctuations, 1939-1948

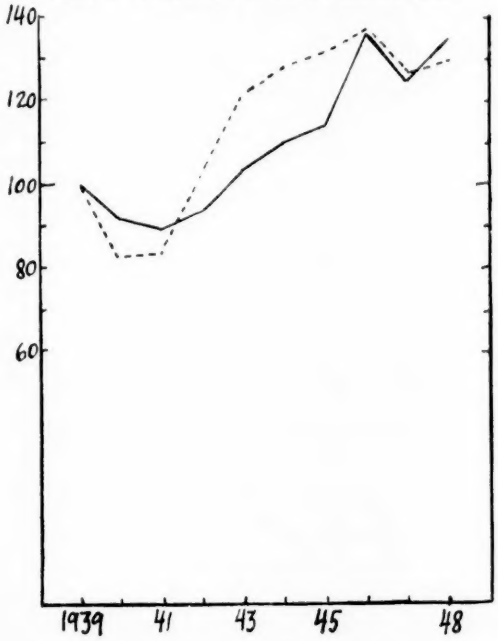
If the crude admission rates are corrected as to transfers, one obtains comparative rates of 7,200, 6,600, and nearly 12,000 admissions for the years 1939, 1940, and 1948. The respective indices are 100, 92 and 166 (Figure 3). In other words, there was an increase of 66 per cent (16 per cent caused by changes in registration, etc., in addition to a real increase of 50 per cent) in the number of mental patients hospitalized within the period of 10 years.

Of this increase, about 10 per cent is accounted for by an increase in the total population, while nearly 40 per cent constituted a real increase (per 100,000 persons). There was no significant change in the sex distribution during the period, and only a minor change in age distribution.

Other determinative influences, which are to be considered in an analysis of the available admission data as illustrated by the fluctuating shape of the previously discussed curve (Figure 3), may have arisen from one of the following four comparative categories: (1) Admissions to mental hospitals and psychiatric clinics; (2) male and female admissions; (3) admissions from different parts of the country; and (4) differences in diagnostic classifications. Unfortunately, no distinction can at this time be made between first admissions and readmissions. It may be noted, however, that the absolute data for the other comparisons have, whenever possible, been converted into rates related to 100,000 persons or to 100,000 males (females) over 15 years of age in the various hospital districts.

1. As far as differences between *psychiatric clinics* and *mental hospitals* are concerned, it is of interest that the decrease in admissions (Figure 4) until 1940 was more pronounced (17 per cent),

Figure 4. Comparison of Clinics and Hospitals

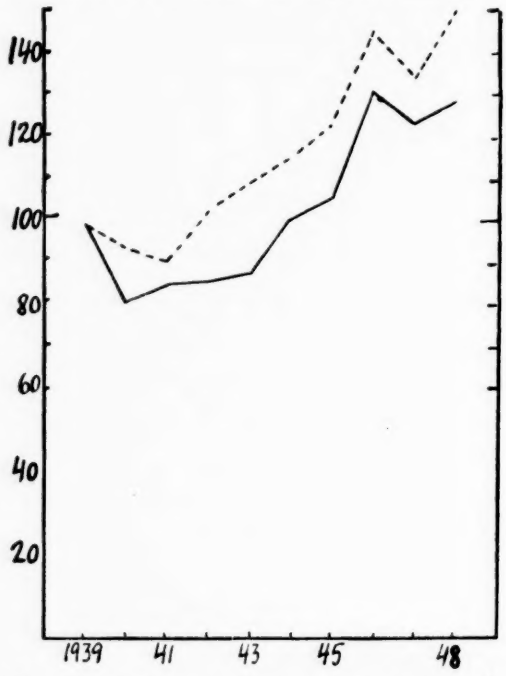


Index values for annual admissions (per 100,000 persons) to psychiatric clinics (- - -) and state hospitals (———) 1939-48, with the 1939 figure rated as 100.

and the onset of the subsequent increase was earlier and more dramatic, in the clinics than in the hospitals. The duration of the decrease in the latter was prolonged to such an extent that the 1939 level was not essentially surpassed until 1946.

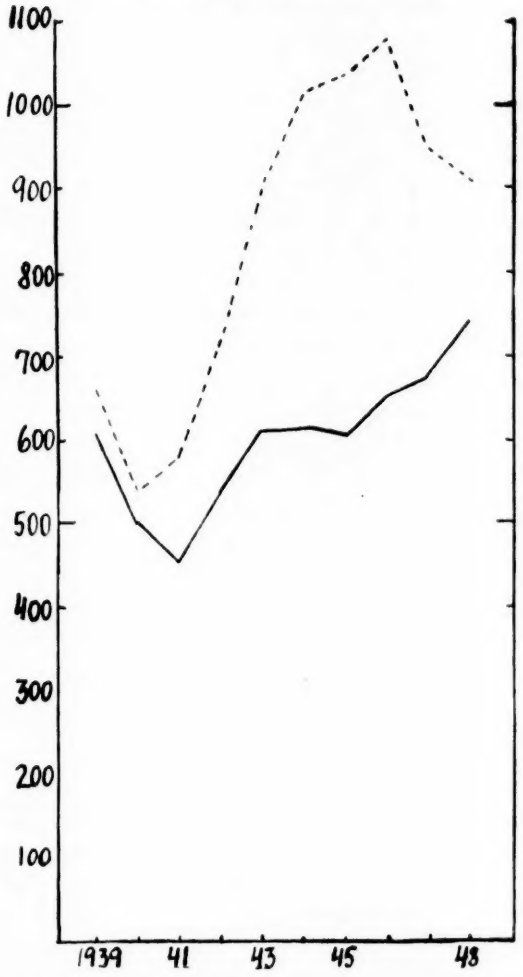
2. A comparison of male and female hospital admissions (Figure 5) reveals that the initial decrease was preponderantly male (20 per cent in 1939-1940) and lasted until 1944, while the subsequent increase was preponderantly female. The clinic admissions (Figure 6) showed corresponding differences, which were even more pronounced. There was a 62 per cent increase in female admissions from 1939 to 1946, and the sex difference would have been even higher without a statistical correction, which has been made for the known preponderance of the female sex in the population of Copenhagen.

Figure 5. Sex Differences in Hospital Admissions



Annual male admissions per 100,000 male persons over 15 years of age (———) and the corresponding female rates (- - -) for mental hospitals 1939-1948.

Figure 6. Sex Differences in Clinic Admissions



Annual male admissions per 100,000 men over 15 years of age (———) and the corresponding female rates (- - -) for psychiatric clinics of the Copenhagen City Hospital and the Bispebjerg Hospital 1939-1948.

3. Since every institution serves a different district, a *regional* analysis can be made for the mental hospitals. Of course, the trends in the Copenhagen population practically duplicated those observed in the psychiatric clinics.

Outside of Copenhagen, the hospital admissions varied almost as much from hospital to hospital as they did within each hospital from year to year. Since the individual fluctuations were not consistent, it is possible only to speak of certain general trends for various groups of hospitals.

The western hospitals as a whole had an initial decrease in admissions, with a preponderance in the male sex, while the subsequent increase was preponderantly female. The corresponding variations in the two eastern hospitals were so obscured by extrinsic factors that they cannot be used for comparative purposes. The fluctuations observed in North Schleswig differed to some extent (prolonged decrease and no excess of female admissions over the 1939 level until 1945), among other things probably because extensive emigration during the German rule (1864-1920) led to special conditions in this borderland district.

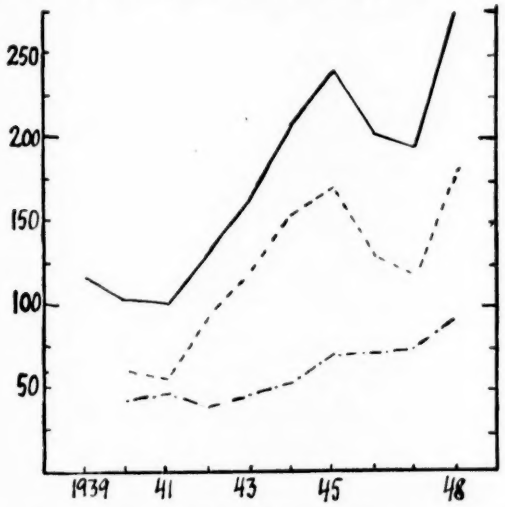
4. Variations in relation to *diagnostic* classifications are to be interpreted with the utmost caution, since it is known that psychiatric diagnoses are affected by various administrative imperfections and regional idiosyncrasies. It may be stated, however, that the decrease in admissions observed in all the western and one of the eastern mental hospitals extended to the majority of the main diagnostic categories (psychoses, psychoneuroses and psychopathic personalities), with the exception of female psychoses. On the other hand, the subsequent increase was due largely to female neuroses and psychoses, especially to "situational" ones. During the entire decade, there was a decrease in the schizophrenic rates, apparently because of significant changes in the diagnostic criteria used. By comparison, the admission of manic-depressive patients remained fairly constant.

With respect to admissions to psychiatric clinics, it seems advisable to use the absolute figures for the Copenhagen University Clinic, although it has been impossible to convert them into rates per 100,000 persons. As to diagnostic categories (psychoses, neuroses, psychopathic personalities, oligophrenia, mental disorders in children, absence of any mental disorder, and attempted suicide), the admission rates of this clinic showed an initial decrease, which lasted until 1941 and affected all the main diagnostic groups, except that of oligophrenia. The subsequent increase was distinguished by three different trends:

(a) The admissions of oligophrenics and psychopathic personalities were characterized by an increase, which was limited to the war years 1942-1944 and revealed an excess of females. Since the end of World War II, the admissions of oligophrenics to psychiatric clinics have decreased steadily.

(b) Suicidal attempts (Figure 7) showed an increase, which reached its peak only in the years 1944-1946 and was followed by a moderate decline in the most recent years (except for 1948). The rise in the male suicide curve was quite consistent, while the female rate revealed a marked increase toward the end of the war.

Figure 7. Admissions of Attempted Suicides to the Copenhagen University Clinic

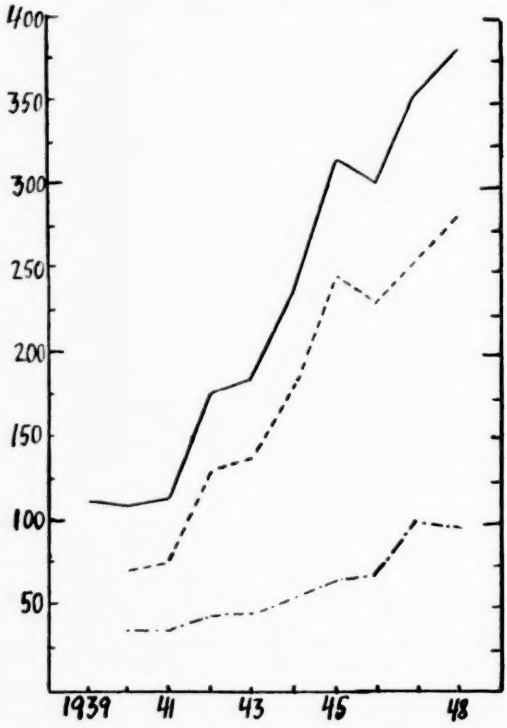


Annual number of attempted suicides (absolute figures) admitted to the psychiatric clinic of the Copenhagen University Hospital in the period 1939-1948; males (— · — · —), females (- - -), and all admissions (———).

(c) The other diagnostic categories—psychoses, neuroses (Figure 8) and absence of mental disorder—were distinguished by a marked increase during the war years, which continued into the postwar period. The increase in the female rates during the period was particularly excessive with respect to the last two categories (300-400 per cent).

Of course, the category of greatest psychiatric interest is that of apparently reactive psychoses, especially reactive depressions and other situational reaction syndromes (Figure 9). In this category,

Figure 8. Admissions of Neuroses to the Copenhagen University Clinic

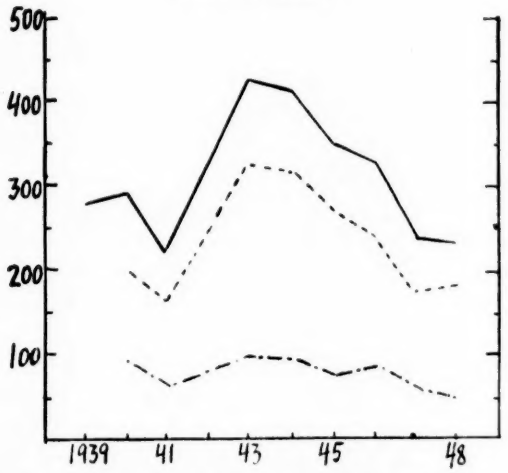


Annual number of neuroses (absolute figures) admitted to the Psychiatric University Clinic 1939-1948; males (— · — · —), females (- - -), and all admissions (———).

there was a moderate decrease until 1941, which was followed by a sudden rise in 1942-1943 (exclusively caused by female admissions and resulting in a virtual doubling of the total rate) and by a gradual decline in the remaining years till 1947-1948.

In addition, it may be mentioned that senile psychoses showed a slight and rather irregular increase. Parenthetically, it may also be recorded that in the years 1940-1946, there was an 800 per cent increase in the number of cases admitted for the purpose of having early pregnancies interrupted. In 1946, about 150 per 100,000 females over 15 years of age were admitted for this purpose in Copenhagen. In approximately one-half of this special category of hospital admissions therapeutic abortions were performed.

Figure 9. Admissions of Apparently Reactive Psychoses to the Copenhagen University Clinic



Annual number of patients (absolute figures, 1939-1948) admitted to the Psychiatric University Clinic with psychoses classified as reactive (situational); males (— · — · —), females (- - -) and all admissions (———).

Specific Causes of the Recorded Variations in Admissions

An attempt to correlate the variations observed in admission rates with any of the usual factors presumed to have a bearing on psychiatric morbidity (such as epidemics, total mortality or fluctuations in unemployment) has been entirely unsuccessful. It seems reasonable, therefore, to consider those particular changes in the emotional atmosphere, which were brought about by World War II.

Without much preceding warfare, Denmark was occupied by German troops on April 9, 1940. At the outset, life under the conditions of occupation was remarkably undisturbed. However, as general feelings of insecurity established themselves and personal anxieties concerning the future became intensified, a growing antagonism between native population and occupation forces developed. In 1943, the elimination of the Danish government was followed by increasing German terrorism (mass raids, arrests, deportations, bombings and retaliatory "random" executions as punishment for sabotage).

As a result, the Danish people became more and more unified. In contrast to certain pre-war signs of withdrawal and indiffer-

ence, they demonstrated a growing interest in political events and a compensatory pride in the cultural heritage of an old nation fighting for its survival. To the same extent as was observed in other countries by Abély, Gillespie, Hemphill, Hopkins, Lewis, Saethre and others, the unusual political circumstances resulted in a real decrease in psychiatric morbidity rates. This decrease was associated with a temporary rise of the threshold of hospitalization (1940), partly because of deteriorated traffic conditions.

Some of the increase in admissions that was observed during the second part of the occupation was probably ascribable to the immediate effects of growing political terrorism. However, equal importance was evidently attached to a severe disintegration in family relations during the period. Many men left their homes to accept employment far away from their families or to escape arrest and deportation. The consequence was that women were exposed to unusual strain and stress because of broken homes, disappointments in love affairs and the need of self-support under difficult conditions of housing. It was no surprise, therefore, that the increase in reactive mental disorders was more or less limited to the female sex.

The increase in morbidity, which occurred after the liberation of the country, was apparently caused by a general "let-down" in the emotionality of the people. A sudden relief from prolonged tension was calculated to contribute to the development of psychotic reaction syndromes.

Principal Results and Conclusions

The initial decrease in admissions to Danish mental institutions, as observed during the first two years of the German occupation (1940-1941) and summarized in Figure 3, may be attributed in part to an increased threshold of hospitalization and in part to a real decline in psychiatric morbidity rates. This decline was especially pronounced with respect to reactive mental disorders and favored the male sex, apparently as the result of general psychological reactions to the occupation.

In the years 1942-1945, there was a 50 per cent increase in admissions over the 1939 rates, mostly on account of a marked rise of situational reaction syndromes in women (disintegration of family life caused by the hazardous conditions of occupation). That this increased demand for hospital beds could be accommodated—

in spite of the growth of the total population and of a gradual decline in the threshold of hospitalization—was made possible by a reduction in the duration of hospitalization following the introduction of shock treatment rather than by an expansion of hospital facilities as has been maintained by some writers.

During the last three years of the period investigated (1946-1948), psychiatric admission rates returned to a relatively even level, and mental hospitals moved again into the shadows cast by a perennial shortage of beds. This deplorable state of affairs obviously called for a well-planned expansion of the total hospital capacity, but has been perpetuated by the repercussions of the current economic situation of the country.

In conclusion, it may be stated once again that a great number of general statistical factors must be taken into account before it is permissible to infer real fluctuations in morbidity. Apart from significant variations in total population size and in the particular aspects of its age and sex distribution, there are three sets of factors which may be responsible for changes in admissions to mental institutions:

(1) Nosocomial factors, which refer to the effect of inadequate hospital facilities, especially to a shortage of hospital beds. If admissions are delayed by the existence of a waiting list, their variable rates are largely determined by the number of discharges (including deaths) rather than by fluctuations in morbidity.

(2) Factors which change the threshold of hospitalizations and thereby modify the proportion of mental patients requiring admission. Evidently a lowered threshold tends to simulate an increased morbidity rate.

(3) Factors which cause real changes in the number of mental disorders in a given population and, therefore, modify the number of cases requiring psychiatric aid in clinics and mental hospitals.

An analysis of Danish admission rates for the years 1939-1948 reveals that *true morbidity fluctuations* occurred in the Danish population during the period, apparently under the impact of the German occupation and irrespective of the effect of other modifying circumstances, the proportional significance of which has been evaluated for each set of factors.

In recent years, however, the usual conditions prevailing in the care of mental patients have re-established themselves in Denmark, due to a deplorable, but at present financially unconquerable, shortage of hospital beds.

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VALIDATION OF LIBIDO THEORY*

S. MOUCHLY SMALL, M. D.

Presenting material relating to a disputed theoretical subject—a specific problem in psychoanalytic psychology—without sufficient space to develop the necessary historical background and the proper frame of reference, invites misunderstanding and misinterpretation. However, the problem may be overcome in part if the clinical material is grounded in an area already familiar to the reader. With this objective, observations made on patients where the physiologic participation in fantasies and emotional attitudes was particularly lucid have been selected for presentation here.

Validation of a psychologic theory requires more than clinical usefulness. Concepts may have to be modified repeatedly, or even rejected, in the light of new facts derived from additional studies. It is especially desirable to be able to gain support for such a psychologic theory from related fields which are in a more advanced state of scientific development. Psychosomatic disorders, by their very nature, provide an effective linkage between psychologic and physiologic phenomena. Clinical observations at an organ-functional level may be directly correlated with subjective statements concerning thoughts, fantasies and affective states, and thus serve as proof or at least as highly suggestive indicators of validity of a theory.

The dynamic concept of instinctual drives and its extension in libido theory form one of the fundamental contributions of Freudian psychology. We are aware that we do not perceive instincts as such; we cannot describe an instinct or measure its quantitative impulse or direction. It is primarily through the manifestations of these instinctual drives at a behavioral level that we are able to infer, or, by a process of extrapolation, evolve the characteristics of these instinctual forces.

Where does this driving force come from? Where does this energy which is associated with the manifestations of instinctual drives come from? In one of Freud's earliest papers he pointed out that we must eventually go back to the biochemical basis, to the biological constitution of the individual, to find the source of these "urging energies." The several tissues and bodily organs

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constitute the matrix in which energies or drives are generated. The expression of these urges to action may be noted in behavior which involves certain areas of the body or in symptoms. Sexual or libidinal drives characteristically become attached to several prominent areas referred to as erotogenic zones. The physicochemical economy of the body, which is the source of instinctual energy, may utilize such zones as the mouth, anus and genital area to achieve expression. The particular form of behavior, or the channel selected for instinctual gratification, depends upon a multitude of individual determinants as well as upon sociological and cultural factors.

It is noteworthy that the commonly favored erotogenic zones of the body are typically areas where skin and mucous membranes meet. It is this particular type of junction which seems to have special characteristics in terms of potential capacity for arousing intense feelings and emotions. These areas may be looked upon as orifices and are for the most part external. They can be manipulated, and such stimulation not infrequently is associated with a pleasurable feeling tone. Furthermore, symbolic values and associated fantasies may be related, in one's thinking, to such areas and thus enhance the feeling. A common example would be masturbatory activity involving a particular part of the body and the increase in gratification experienced when a desirable fantasy accompanies the act.

Not only stimulation *per se* but a certain type of characteristic stimulation seems to have additional value. For example, a rhythmic type of stimulation rising in crescendo-like form to a peak has particular excitatory value.

Under special conditions such as surgical intervention, parts of the body not ordinarily exposed are brought to the surface, a mucocutaneous junction is formed, and its erotic significance may be evaluated. This provides the opportunity to study the psychophysiology of such an organ. Furthermore, the individual is in a position to become more aware than previously of local reactions and subjective experiences. He can now see, touch, and feel the newly exposed part. Observing changes in its form and color as a result of manipulation or personal fantasies leads to a much more vivid type of subjective description. This is a new organ, not subject to taboos or inhibitions that may have been associated with other parts of the body.

In the two cases to be presented, it is of interest to note not only the patients' experiences but how others who came into contact with them reacted to their behavior, often without realizing what was annoying them.

The first patient was a 36-year-old man who was admitted to Mount Sinai Hospital, New York City, in March 1947 with a 17-year history of ulcerative colitis. His original admission in 1930 occurred shortly after his mother's hospitalization for hysterectomy. At that time he complained of bloody, loose bowel movements, abdominal cramps and a weight loss of 40 pounds. During his hospital stay, the diagnosis of chronic, nonspecific ulcerative colitis was confirmed by x-ray and sigmoidoscopic studies. Blood agglutination tests for specific dysentery organisms were all negative. No ova or parasites were found in the stools. The hemoglobin had fallen to 42 per cent. Medical treatment with opiates and repeated transfusions led to marked improvement with relief of abdominal pain; a 13-pound weight gain, and an increase in hemoglobin to 68 per cent. The appearance of the mucous membrane on sigmoidoscopy was almost normal.

About six months later, this man was readmitted because of migratory polyarthritis and a recurrence of bloody diarrhea. He again responded to medical therapy and was fairly well for a period of 11 years until his first child was born. He related minor exacerbations to situations of emotional strain and also reacted to the birth of his second child with a temporary return of symptoms. His admission in 1947 was occasioned by severe diarrhea, with 20 to 25 watery bowel movements daily, accompanied by intense abdominal cramps. Examination revealed widespread involvement of the rectum, sigmoid, and distal end of the descending colon. Sigmoidoscopy revealed thickened, granular, friable mucosa, covered by a purulent exudate. Medical therapy was of no avail. He was transferred for further study, to the psychiatric ward, where it was decided that an ileostomy should be performed. This he refused, saying he didn't want to be cut—he didn't want to have an opening in his abdomen. He preferred to take his chances on living with his colitis rather than submit to operation.

Psychiatric investigation disclosed that this patient was an only son and that, soon after his birth, his father had emigrated to this country alone, the baby then had developed an unusually close emotional relationship with his mother. He was a bed-wetter until

the age of five. When the boy was eight, he and his mother rejoined his father; and he thenceforth felt neglected and deserted by the mother who no longer gave him the tender, loving care he had previously received.

As a youth, the patient's college career was interrupted by his first illness and was never resumed. Sexual education had been neglected at home; and most of the boy's information was gathered from his playmates. Masturbation with heterosexual fantasies began at 13 and persisted until 18, when it was discontinued because of increasing guilt feelings. He avoided girls because of an exaggerated fear of syphilis. A year later, and corresponding to the time of his mother's hysterectomy, his initial symptoms appeared.

The patient's first marriage, at 25, to a neighborhood girl, was loveless and lasted for but one month. He had apparently married her to show his gratitude to the girl's mother for saving him from gas asphyxiation when he was nine. After three years he remarried, this time without the recognition of the church. He expressed the belief that the rectal bleeding was a form of "purification for the sin of remarriage." His second marriage was stormy, with frequent interference from his mother-in-law, who insisted that her daughter have an abortion soon after the marriage. This was done without the patient's knowledge or consent; and he afterward distrusted his wife, which led to bitter quarrels. Following the birth of the first child, his wife was compelled to work, and his mother took over the care of their child.

The patient was always perfectionistic, neat and meticulous, and was constantly concerned with finances and social acceptability. He was given to outbursts of rage against his wife and father; but these were never directed against his mother. He maintained an infantile, dependent relationship toward her, repeatedly seeking her attention.

Finally, after considerable indecision, he agreed to the ileostomy if he could have the privilege of returning to the psychiatric ward shortly after the operation. He wanted the psychiatrist to look after him through this difficult period. (He stayed, however, on the surgical service.)

At operation, the diagnosis was confirmed with the addition of marked inflammation of the transverse colon. Following the operative procedure, he responded with a prompt subsidence of fever,

and began to gain weight. He remarked that he felt fine, and was in good spirits. There was a slight amount of bloody drainage from his rectum, but this cleared up after a few days.

Following recovery from the ileostomy, the patient insisted on taking care of the stump himself, maintaining scrupulous cleanliness with neat applications of an aluminum paste to the surrounding skin. The surgeon who operated on him would demonstrate the patient "on grand rounds" as an example of the proper way to take care of an ileostomy. He seemed to spend considerable time cleaning the ileostomy and applying fresh dressings. When, as part of the usual procedure, he was approached for a fitting for an ileostomy bag he refused to have one. He stated that he did not want a bag—that he preferred to continue taking care of it himself as he had been doing.

At the time of the operation about two inches of ileum was delivered through the abdominal opening to allow for subsequent contraction. On one occasion, the patient spontaneously asked the psychiatrist if he wanted "to see something." He retreated behind closed curtains around the bed, removed the dressing and began rubbing the protruding ileum with a gauze pad. As he did so, he smiled and appeared to enjoy watching the piece of small intestine. The ileum, which was flabby and pink, became more engorged with blood and took on a bright red hue. In addition it contracted and became stiffer; and after a short while, fecal contents began to flow out of the opening. When he was asked what this was all about, the patient laughed out loud and said, "You know, like when you rub down here"—pointing to the genital area. In response to further questioning, he indicated that the feeling was of a similar type, and that rubbing the ileum gave him a markedly pleasant sensation. He didn't mind at all the job of cleaning the area, perhaps a dozen times a day.

Interestingly, the nurses became annoyed with this man. When asked why they seemed to dislike him, they were vague, and could only answer that "he spends so much time 'fooling around' with his ileostomy." They felt there was "something peculiar" about it; and for some reason, which they were unable to verbalize, they just didn't like it. When pushed for a more adequate reason, one of the nurses put it on an economic basis: "Look at all the pads of cotton he's using. We can't keep getting him pad after pad."

During the patient's previous stay on the psychiatric service, he had struck up a close friendship with an orderly who had homosexual inclinations. This orderly regularly visited the patient on the surgical service, where he was finally content to remain, despite his previous insistence on returning to the psychiatric ward. At first, he seemed to enjoy the orderly's visits; but after a while he asked the psychiatrist to keep this fellow away. When his wife came to visit he would at some time during her stay, draw the curtains around the bed and enlist her aid in cleaning the ileostomy and changing the dressing. He was perfectly capable of doing it himself, yet every visiting hour was the signal for the two of them to work over him. The nurses insisted that he stop this during the visiting hour and wait until the visitors left.

Following this edict he seemed to lose interest in his wife's visits but he struck up a close relationship with a 19-year-old boy who was ambulatory following an appendectomy. The two of them would work on the ileostomy together.

His appetite was voracious, and he gained about 20 pounds in a few weeks. During one of the talks with the psychiatrist, when discussing the return of his appetite, the patient volunteered that he liked to eat, and added: "It gives me more stuff to come out"—referring to the ileostomy.

With the passage of time, the ileostomy became more everted and began to retract a bit, as had been expected. It seemed to be getting smaller and shrunken. The patient asked to see the psychiatrist as soon as possible when he noticed this. With considerable anxiety, he indicated what had happened and asked. "It won't get any smaller, will it?" He appeared to be considerably upset about this occurrence. The obvious relationship between the degree of manifest anxiety and his undue concern about the size of the stump, regardless of the fact that it was functioning satisfactorily, was impressive. This patient carefully observed every little change in the protruding portion of the ileum.

It is apparent that this man was treating his ileal stump as a displaced genital organ and that he derived an orgastic type of pleasure from manipulating it. Unless one knows more about his early psychosexual development, it is hard to understand why he could not indulge in direct masturbatory activity. Without going into too many details, the patient was able to recall being caught handling his genitals by his mother when he was about five years

old. It was at this time that he was very close to his mother, who reciprocated his affection. Her husband was away, and she naturally invested her deepest affections in her son. While he was not aware of a desire to replace his father or of any outspoken incestuous fantasies, his dreams indicated the presence of such unconscious drives. With the recurrence of masturbation in adolescence, he was aware of deep guilt and anxiety. Even in intercourse with his wife, he had occasional periods of impotence. It appeared that almost any kind of genital sexual activity was laden with considerable anxiety. Concomitant with this, he expressed exaggerated fears of syphilis and he was deeply afraid of suffering some injury to his genital organ. The need to regress, as part of a defensive maneuver, to pregenital interests and homosexual or auto-erotic practices is now more comprehensible.

The genital area was, as it were, forbidden soil. It was a part of the body that was directly involved with his guilt feelings. However, when he received a new organ to play with—one which did not have any religious, cultural or personal taboos associated with it—he could then allow himself free indulgence. Here was a new opening from which he received gratification without any qualms. On the contrary this was an organ, given to him with the surgeon's blessings, which he had to touch, rub and keep clean. As a matter of fact the more "he fooled around" with it as part of keeping it clean and neat, the greater approval he received on grand rounds.

In a classical paper written in 1910, entitled, "Psychogenic Visual Disturbances According to Psychoanalytical Conceptions," Freud pointed out that when an organ is used for an erotic gratification, it will tend to interfere with its normal physiological functioning. He stated: "It is never easy to serve two masters at the same time. . . . When an organ which serve two purposes overplays its erotogenic part, it is in general to be expected that this will not occur without alterations in its response to stimulation and in innervation, which will be manifested as disturbances of the organ in its function as servant of the ego."

Experience with this patient tends to confirm and validate the concepts of displacement of libidinal energy and the fact that various parts of the body or various organs may become erotized. There is little doubt that, both objectively as well as from the standpoint of the patient's subjective experiences, the ileal stump behaved like a genital organ and was associated with characteristic

fantasies related to such organs. This man has since had a subtotal colectomy with further improvement.

The second patient was a 36-year-old lawyer who first came for psychotherapeutic treatment approximately six years ago because of intermittent and varying degrees of impotence. He wished to get married and was financially capable of doing so but was afraid that he would not be sexually competent.

He was an only child. Prior to his birth, his mother had had several spontaneous abortions; and she was 40 years old when she finally gave birth to this child. He was breast-fed until nine months of age. As a child, he was always meek, passive and proper and did excellent work in school. He was the pride of his family. As he talked about his early life, it became apparent that he was a severe compulsive character, who, in addition, had certain neurotic symptoms of an obsessive-compulsive variety which complicated his ability to get his work done.

The following information came out over a period of a year and a half of analytically-oriented psychotherapy during which the patient was seen once or twice a week. He recalled that at four to five years of age, he would often take naps with his mother, on which occasions he would suck at his mother's breasts. His mother did not seem to mind, and, on the contrary, seemed to be enjoying the procedure. Despite this, he recalls that he would always be afraid of his father coming home; and such activity was always indulged in long before the time arrived for his father to return from business.

Further indications of oral interests came out in the fact that he was a finger-sucker, using the third and fourth fingers of his left hand, until he was six years old. He indulged in this rather persistently so that he first distinguished left from right by the teeth marks on the fingers of his left hand. This was a big joke in the family.

He bit his fingernails until he was 14, after which he first stopped and then resumed the habit on various occasions. It was at this age that he first began to have symptoms of colitis.

His memory for the events of his early life was rather good, but as he talked about them, he showed relatively little emotional excitement. He seemed to dissociate intense feeling from these memories, with the latter remaining quite clear. He recalled defecating, at four years of age, under the front porch in company

with the maid's daughter who was about the same age. He felt rather excited about it, even though at that time he knew it was something to be hidden because it was wrong. At seven or eight, he had repetitive nightmares having to do with piles of coal which he equated with feces.

In his pre-adolescent years—up to 12—he thought of the female organ as being "a dark brown hole in the abdomen." Associated with this, he had a fantasy of putting his penis in a neighbor girl's umbilicus.

Genital masturbation began at 12, but without ejaculation. Concurrent with this, he first experienced abdominal cramps. When he complained of abdominal pain, he would lie in bed, and his mother would rub his abdomen. This invariably resulted in relief of the pain. At this time he had a fantasy that his mother would invite him to have intercourse with her, but the boy never made any advances along these lines. His abdominal pains continued intermittently until he was about 14, when he was sent to a camp for the summer. While there, he began to have severe diarrhea with 15 to 20 bloody stools a day and a loss of 25 pounds in weight. He was brought home, and an appendicostomy was performed.

Following the operation he went to the country with his mother, the father remaining at home. He and his mother shared one room in which they had twin beds. His mother was extremely nearsighted as a result of severe diabetes. When she would take off her glasses she could hardly see beyond the tip of her nose. On many occasions while his mother was in one bed, without her glasses, although still awake, and he was in the other, he would masturbate without ejaculation. He recalled that his penis was so small at the time that he could only use two fingers to masturbate. It was with envy that he often thought of the large size of his father's penis.

On one occasion when he was masturbating vigorously, he evidently hurt or irritated himself and he noticed some bloody fluid coming out of his penis. He became extremely frightened and stopped genital masturbation immediately. Since he then had an appendicostomy he began to focus considerable interest on this opening. He would squeeze the appendicostomy from all different sides in an effort to clean it. He would squeeze and squeeze in order to get the last bit of feces out from the opening. He remarked that this gave him a pleasurable feeling and had a certain

tickling quality. This he would do in front of his mother even when she was wearing her glasses. When she would insist that he stop, that he was going to irritate the opening, he would rationalize his behavior by saying that he wanted to get all the feces out and keep it clean.

When he was 15, an attempt was made to close the appendicostomy but the closure would not heal. He developed a fistula, and it kept draining. This frightened him considerably since he felt that he must have injured the appendicostomy in some way with his repeated manipulations. It remained open for a full year and, interestingly enough, began to close at a time when he began to indulge again, in genital masturbation which now was accompanied by ejaculation. Even though he had considerable apprehension concerning auto-erotic practices, in terms of "causing insanity" or permanently injuring his genitals, he continued masturbation for many years.

It was not until he was 27 that he had his first heterosexual relations with an aggressive girl who made the advances and really seduced him. He was troubled by ejaculatio præcox and, not infrequently, was unable to maintain an erection. At the times when he was successful in completing coitus, he still felt the urge to masturbate following intercourse, because the latter did not completely satisfy him.

During this same year, his mother developed a severe itching neurodermatitis involving her whole body. One day he "happened to walk into his mother's bedroom" at a time when she had her genitals exposed and was scratching herself. He was struck with a terrific sense of revulsion and disgust at what he saw, but the vivid quality of this incident remained clearly in his mind.

The following year his mother became severely depressed and committed suicide. When this occurred, the patient's father was broken up about it and wanted the patient to sleep with him. He felt squeamish about doing so but nevertheless did go to bed with his father. One night his father's penis accidentally rubbed up against him and the young man became so panic-stricken he practically jumped out of bed. His father then began to make increasing demands upon him to come home for dinner, to spend the evening with him and to go visiting with him. The father became extremely possessive—to the point where the patient would have to break dates with girlfriends in order to keep his father company.

He experienced considerable guilt feelings when he would become aware of wishing that it was his father who had died in place of his mother. He discussed many passive homosexual fantasies of this period.

Improvement under psychotherapy was progressive, with a decrease in his obsessive-compulsive tendencies. He was able to open his own office, had many dates with girls, and impotence was no longer a problem.

He was working long hours when he contracted tuberculosis and had to be hospitalized and placed on bed-rest. He did not respond well and pneumothorax and finally a thoracoplasty were performed. During this period he communicated with the writer by letter. He had a severe cough and received considerable amounts of codeine to diminish the cough reflex. He wrote in part, as follows:

"I have been meaning to write you for several weeks, but I have been procrastinating, probably because the whole subject matter is unpleasant to put down on paper, especially the latter half." In the letter he went on to tell how his tuberculosis was improving with streptomycin, codeine and the operative procedures. He had been told that the codeine would probably constipate him and that he might have some diarrhea when the drug was discontinued. Accordingly, it had been discontinued slowly. Despite this, he began to have severe diarrhea with blood and pus in his stools. He wrote, "When I first became sick I was warned that the codeine I was taking would result in constipation. It did a bit but not seriously. About a month after I first took sick my t.b. doctor took the codeine away. At once my bowels became loose, and this condition became progressively worse until I was having six or seven very watery stools a day, together with much gas, some blood, and distress.

"I have always been permitted toilet privileges, and this walking back and forth was pretty exhausting. The doctor said that diarrhea or constipation was not unusual with tuberculosis patients and treated my condition first with boiling my milk, then by giving it to me warm, then he gave me a medicine containing pectin, then bismuth powder, and then a tablet that I don't know the name of, all of which time I was also taking about a quarter of a grain tablet of phenobarbital three times a day. He also put me back on codeine but nothing would help."

However, after about two weeks his colitis improved and he began going to the toilet only about two or three times a day, "I had less gas and pain; the quality of the stools stayed loose and watery but this was a great improvement. "Please remember," he writes, "the point at which I got better. It is seven or eight days ago now, and it will tie in with what I will tell you later."

Strangely enough, he lost relatively little weight—only about four pounds. "And now I have to go back to the beginning again." He continued, "Right from the beginning, I gave up smoking with no effort and have had no strong desire to smoke again. I used to smoke two packs a day. I have stopped completely and have no desire to start that again.

"I had been quietly congratulating myself on both accomplishments and wondered if it would continue thus once I was out of bed and back in a normal life again. In the beginning I also had a worse-than-usual fear of wet dreams, because of the daily visits of the visiting nurse. She used to come in to give me the streptomycin. I also used to worry as to whether I would get an erection during my bath from her, and I would worry about strange nurses coming in.

"I soon discovered, however, that I was completely asexual—that is, no sexual interest at all. I apparently had repressed everything so that I had no fantasies or anything of that sort at all.

"I would skip over parts in books that I was reading describing about screwing, and so on, just so as to avoid fantasy. I put the fact of no wet dreams up to my weakened condition. Then about two weeks ago I suddenly remembered you had once remarked something like, Where does the libido go?

"Then I began to wonder if my libido hadn't gone from my penis to my colon. I wondered if I could bring it back, and whether that would cure the colitis. I tried deliberately to have sexual fantasies, with only fair success, with A [she was the first girl with whom he had had sexual relations].

"Then last week, the date or point I mentioned before, I masturbated twice, and then again two days later, thinking always of A, and this was pleasurable." Although he is a professional man of superior intelligence he continued, "It was probably a coincidence that my condition approved [*a*-p-p-r-o-v-e-d] at the same time I first masterbated [m-a-s-t-*e*-r-b-a-t-e-d], or was it?" (Masturbation was spelled correctly in other parts of the letter.)

These two "slips of the pen" betrayed the inner conflict which in fact had arisen during his psychotherapeutic treatment but was never adequately analyzed. Whenever he discussed masturbation he sought the writer's approval in various ways. He spoke of its frequency in the general population, rationalized such activity as safer than going to a prostitute and persisted in trying to get the writer to tell him it was permissible. When this approbation was not forthcoming he interpreted silence on the issue as a tacit approval since the writer had not specifically interdicted masturbation. At least that was the way he was going to take it.

The unsuccessfully repressed conflict, expressed itself again in a renewed demand for approbation accompanied by "medical proof" of its importance for his health. It is as though he were insisting, "Masturbation is desirable—it cured my colitis." In the face of such dramatic relief from bowel symptoms coincident with the return to genital masturbation, his indirect plea for approval could not go unanswered.

He continued to improve rapidly, gaining weight from a low point of 75 pounds to 156 pounds. The tuberculous infection is quiescent, and the colitis symptoms have cleared up. In view of the persistence of neurotic difficulties, he intends to resume psychotherapy.

This patient, like the first one described, demonstrates how a new orifice may be utilized for erotic gratification. The outlet represented a more acceptable area than the genitals for libidinal investment and provided a channel for the previously dammed-up sexual drives. The recurrence of prolonged physiologic disturbances in bowel functioning, precipitated by the withdrawal of codeine, strongly suggests the persistence of anal-erotic fixations from childhood. The functional disturbance was so invested with libidinal values that, even though codeine was given again, the pattern persisted until adequate erotic gratification could be derived from another source, that is the genital area.

It is beyond the purpose of this communication to discuss the etiology of ulcerative colitis and its relationship to character formation, compulsive symptomatology and the way in which specific life situations are managed. However, preliminary experience indicates that patients who have had artificial bowel openings for other reasons—such as carcinoma—do not ordinarily show the same type of erotic interest in their orifices.

The significance of libido theory for a better comprehension of psychosomatic disorders can no longer be overlooked. Repressed or conscious fantasies of organ functioning do, in actuality, lead to expression in distortions of the natural biological processes normally ascribed to such organs. Chronic alterations in function may then predispose toward the development of irreversible structural damage.

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CARBON DIOXIDE THERAPY

BY GEORGE A. SILVER, M. D.

This is a report of the first 100 patients who received carbon dioxide-oxygen therapy at Duke Hospital, January to November, 1951. The inhalant mixture consisted of 30 per cent carbon dioxide and 70 per cent oxygen.

This type of treatment was inaugurated by Meduna[1] for psychoneurotic patients in 1943. His results showed an over-all improvement rate of 68 per cent, and justified continued use and exploration of the method.

The preliminary report[2] based on the first 30 patients treated at Duke University Hospital* showed an improvement rate of 86 per cent. It was stated in that report that some relapses might be expected, and after six months the improvement rate in these original 30 cases dropped to 76 per cent. One case of alcoholism relapsed completely after two months; a depression was unmasked in another patient, necessitating electric shock at a later date; and a "chronic invalid" did not maintain her improvement more than a few weeks after treatment was discontinued. With these exceptions, the remaining patients reported as improved, have maintained the improvement or have continued to improve further.

This present report deals with an additional 70 patients combined with the original 30. The over-all picture showed no improvement in 25 per cent, slight but definite improvement in 27 per cent, marked improvement in 26 per cent and apparent recovery in 22 per cent.

A rather arbitrary classification of psychoneurotic conditions was used, as shown in Table 1.

This classification was used in a descriptive sense to give an idea of the main clinical picture presented by these cases.

Table 2 shows the number of treatments, the time during which these treatments were given, and the improvement shown, divided into columns: No Improvement (O), Slight Improvement (S.I.), Marked Improvement (M.I.), and apparently Well (W). The clinical picture is represented by the initials of diagnoses in Table 1.

This table would seem to indicate that there is little relationship between improvement and the number of treatments given. As

*Durham, N. C.

Table 1

	No improvement	Slight but def. improvement	Marked improvement	Well	Total
Anxiety	6	6	7	4	23
Hysteria	0	0	2	2	4
Depression	5	2	2	6	15
Depression in an anxious person	3	3	4	5	15
Depression in a hysterical person	2	2	3	2	9
Psychasthenia	0	2	0	0	2
Neurasthenia	2	2	3	1	8
Alcoholism	2	1	2	1	6
Stuttering	1	5	0	0	6
Miscellaneous	4	4	3	1	12
Total	25	27	26	22	100

will be noted, a high percentage of the patients treated with 10 or fewer treatments, showed marked improvement, and patients having two or three times as many treatments showed lower percentages of improvement. This is in part explicable because cases not showing improvement with a small number of treatments were continued for a larger number. This longer-continued treatment is apparently justified as shown by the fact that three of eight patients showed marked improvement after more than 50 treatments. The writer feels that a much wider experience will be required before one can accurately determine the kind of case to be treated and the number of treatments required to effect improvement.

Table 2

Number of treatments	Clinical picture*										Treatment given during				Improvement			
	A.	H.	D.	DA	DH	P.	N.	A.	S.	M.	1 Mo.	2 Mo.	3 Mo.	4+ Mo.	O	S.I.	M.I.	W
0-10	1	1	1	1	2	0	1	0	0	3	10	0	0	0	0	4	3	3
11-20	4	2	7	3	5	0	3	4	2	5	32	3	0	0	11	6	10	8
21-30	10	1	5	8	2	1	2	2	1	2	20	9	3	2	12	11	4	7
31-50	5	0	1	3	0	0	0	0	2	2	1	4	6	2	1	2	7	3
51+	3	0	1	0	0	1	2	0	1	0	0	1	2	5	1	4	2	1
	23	4	15	15	9	2	8	6	6	12	63	17	11	9	25	27	26	22

*See Table 1 for diagnostic classification.

There was very little selection of cases for treatment except that, (1) symptoms of depression were not severe enough to necessitate electric shock therapy, (2) no major psychoses were treated, and (3) in general, the so-called psychoneurotic reactions constituted the largest group of cases. They represent the entire first 100 patients treated. With four exceptions, all received at least 10 treatments. In an effort to judge the value of this therapy, some cases believed unsuitable had a trial, at times with surprising results. Two patients who responded well to carbon dioxide-oxygen had had prior classical psychoanalysis without benefit. Some had previous, somewhat prolonged, non-analytic therapy in one form or another. Some—incapacitated for many years and the recipients of considerable and extensive medical attention through those years—were able to make adjustments again and function at a more adequate level.

Under the miscellaneous group are a variety of patients not easy of definite classification, as used here. These cases are summarized briefly.

One woman, whose chief complaint was sexual frigidity, was considered well by both the husband and the patient herself after 10 treatments. One case of back pain, another of side pain, both elusive of diagnosis, were not benefited by the carbon dioxide-oxygen therapy. Two other patients, one with torticollis, the other with writer's cramp, were not improved. A woman who showed some intellectual changes and marked emotional lability, with uncontrollable anger spells, following a cervical operation, was markedly improved to the point that her husband removed her from the hospital against advice after seven treatments; she later wrote for information in order to get the treatments closer to their home.

A 72-year-old man who had difficulty in breathing had no relief from his complaint, but was less disturbed about it and felt stronger, brighter, and in better spirits. A 55-year-old woman, formerly alcoholic, was lobotomized for intractable pain of thalamic origin. Following lobotomy she was relieved of pain and morphine addiction. She became, however, complaining, querulous and reverted to alcoholism. With carbon dioxide-oxygen therapy, she showed objective, but no subjective, improvement. Later she asked to have further treatment and recognized the improvement herself. A patient with a paranoid schizophrenic-like reaction had the main complaint of inability to remember details. His memory

after 16 treatments, improved, and was recovered after 25 treatments. He, also, noticed many other signs of improvement: The most notable was a lessened tension about his homosexuality, and he requested continuation of therapy.

A senile, depressed, physician, with paranoid ideas and "solar plexus trouble" was completely relieved from the epigastric difficulty, had partial relief from the depression and developed insight into his delusional system, but was unable to modify it. A woman of 43, an invalid with multiple sclerosis of 10 years duration with stationary symptoms in the previous three years, had 25 treatments. Except for equivocal changes toward emotional stability, the only definite thing she could report was her ability to do fine and precise motions with her hands again—such as fine sewing. The twelfth patient was a boy of 11, who had *maladie de tic.* In spite of careful medical attention over the previous three years, he had progressed to the point where he had no conscious control over his shoulder and head jerks, gutteral sounds and foul utterances. After 15 treatments, with no other medication used, he was a changed boy. He still has occasional twitches and throat noises when under tension but is a happy, active boy, diligent in home chores and interested in school work.

It is assumed that an individual who comes for treatment is primarily interested in his own well-being. For that reason, his own appreciation and appraisal of his symptomatology has received considerable weight in the evaluation of the results of this form of treatment. The final evaluation of his improvement was the joint opinion of the patient, relatives and the physician's own appraisal. In no case is improvement reported on the therapist's opinion alone. Unless the patient and the family reported definite improvement, it is reported as no improvement. At times, "apparent cure" has been reported as only marked improvement because of the opinion of the therapist. A young man of 34, a psychopathic individual, was hospitalized as an alcoholic primarily because both his father, who was seriously ill, and his mother, a "nervous wreck," could no longer cope with him. He had carbon dioxide-oxygen treatment against his will but co-operated well in every other way. The treatments were discontinued after he had 13. He stated that he was no better and it is so recorded in the table, although it was obvious to medical and ward personnel that he was less "jittery" and restless and had a good sleep pattern. Since he

had never been able to handle responsibility of any kind, it was with considerable surprise that the therapist learned some four months after he left the hospital, that he had been managing his father's business, had not been drinking and to all intents and purposes seemed to be a changed man. As mentioned before, since there were in this case so many equivocal circumstances, it is reported as no improvement in respect to carbon dioxide-oxygen therapy.

Patients listed as showing slight but definite improvement are illustrated by a 36-year-old woman with torticollis who had relief of pain, relaxation of severe spasm and the ability to feed herself for the first time in four months. This woman, partly for financial reasons, but mostly because she was "homesick," decided to return to Florida without sufficient treatment. A 46-year-old, rigid, compulsive woman, treated for spastic colitis, is reported as "slight but definite" improvement. She came a considerable distance to receive 30 treatments but now is able to continue treatment with a doctor in her home town; and, at last report, her colitis was improved and she was less tense and was relieved of indecision. Another patient, a "chronic invalid" for 13 years, became less vociferous in her complaints, developed a good sleep pattern, was relieved of constipation and was more effective about her home.

Marked improvement is illustrated by a neurasthenic who considered himself well after 20 treatments and returned home. He was believed inadequately treated and this proved to be the case. In a letter received three months later, he asked for information about receiving the treatments closer to his home. A very anxious young woman had many phobias and panic reactions and was subject to sleep-walking. After 25 treatments, she was sleeping quietly and restfully, was able to go wherever she wanted and was picking up her social activities after a lapse of two years. More treatment was suggested but did not seem practical to the patient at that time. Another patient, a young man, was incapacitated by vague sharp pains around the region of his heart. These attacks of pain disappeared, and the patient returned to work by the twenty-eighth treatment. Four months later, he reported himself completely well, but had some doubts about cardiac disease.

Perhaps the most dramatic "cure" was the 28-year-old woman, incapacited for three months, sleepless, restless, with marked loss of weight and marked emotional lability, who, after nine treat-

ments, was reported by her husband as, "If it wasn't for the kids, we'd be on our honeymoon." Another woman of 45 who had had three recurrent depressions for which she had received electric shock therapy was started on carbon dioxide-oxygen treatments in her third depression, after failure to recover with electric shock. She felt well after 12 treatments, and the course of treatment was continued to 25. After this first series of treatments, the patient relapsed and carbon dioxide-oxygen therapy was again started. A second course of 35 treatments was followed by relief of all symptoms, and three months later she is still well. An alcoholic young man, the despair of his family, has been well, happy, and productive for six months—the longest period of abstinence in 12 years.

In the administration of the treatment, the policy has been to tell the patient that little can be expected in the first 10 treatments. Improvement is apt to begin between the tenth and twentieth treatment. If improvement occurs earlier, it is likely to be evanescent. If the patient begins treatment, he should be continued for about 30 treatments and if, then, no improvement has occurred, it is unlikely that any will. The treatment should then be abandoned. If there has been some improvement by the twentieth to thirtieth treatment, therapy can be given indefinitely—as long as improvement continues.

The treatments are easy to administer. A tank of the gas mixture made commercially costs about $10 and is sufficient for about 100 treatments. A two-stage regulator allowing free flow of the gas mixture and a mask with a large (five-liter) re-breathing bag are the only other equipment required. The regulator in current use has a line gauge calibrated to deliver up to 60 pounds of the gas mixture per square inch. The treatments are short, the total time varying from five to 10 minutes unless combined with psychotherapy, which is not necessary in the average case. The writer believes the contraindications to the treatment are severe cardiac or pulmonary disorders and excessively high blood pressure.[3] Some caution should be exercized, in the administration of the gas, not to increase the distress of the depressed or anxious patient. The same might be said of the aggressive patient who is likely to have a violent motor reaction early in the course of treatment. The number of inhalations varies with the patient, from 20 to 40 on the average, although 70 and even 90 have been used at one treatment without ill effect.

Some patients have difficulty in taking the treatment because of a feeling of "choking," "strangulation" or, "I can't get my breath." In the writer's experience, this occurred severely in one out of six patients. In his previous earlier experience, treatment had to be abandoned in these cases, and these are not included in this report. Fortunately, on the suggestion of Meduna, this difficulty has been circumvented. Undiluted nitrous oxide was hooked into the system. This gas is administered first for rapid safe anesthesia; and, as signs of anoxia develop (eight to 10 inhalations), the carbon dioxide mixture is turned on. The patient is unaware of this change and usually has no trouble taking the treatment in this manner.

Conclusions

One hundred patients received carbon dioxide-oxygen therapy. There was no improvement in 25 per cent, slight but definite improvement in 27 per cent, marked improvement in 26 per cent and apparent recovery in 22 per cent, over the one to nine months following therapy covered by this report.

Carbon dioxide-oxygen inhalations are easy to administer, are safe and inexpensive, and in the present series of cases, were effective in producing some degree of improvement in 75 per cent of the patients treated.

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DURATION OF HOSPITALIZATION, READMISSION RATE AND STABILITY OF DIAGNOSES IN VETERANS HOSPITALIZED WITH NEUROPSYCHIATRIC DIAGNOSES* †

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The group of persons who compose this study were a 30 per cent random sample of all patients admitted to Veterans Administration hospitals during April 1948, who were diagnosed as having disorders of a psychiatric or neurological character. Each of them was traced from the date of his April 1948 admission through April 1950. The discharges, readmissions and diagnostic appraisals on each hospitalization were incorporated in the record.

Some of the limitations of the record should be pointed out. The nature and extent of hospital care of these persons previous to April 1948 is unknown. The first admission in this study may not by any means be the first admission of the patient for his current illness. The patients first appear in the record as a group of approximately contemporary admissions to VA hospitals. They are veterans, and, on this appearance, they were admitted for treatment or observation with psychiatric or neurological diagnoses.

The number of admissions and the reported diagnoses are represented with assurance that there were at least these admissions and diagnoses for each veteran reported. There is no such assurance that the search of records disclosed every hospitalization in a VA hospital. A few may have been missed. Nor is there any reflection in this material of hospital care in other public or private hospitals. As a consequence it must be assumed that there were some hospitalizations of these veterans concerning which the writers have no available records, and that the representations of this study are, therefore, not fully comprehensive.

The unusual characteristic of this material is that it follows the individual patient through repeated hospitalizations, even when they occur in different hospitals. His illness episodes are bridged over interhospital transfers and over other administrative actions within the VA system that are necessarily reported by individual

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†From the Veterans Administration Central Office, Washington, D. C.

hospitals as terminations of treatment. As a result, more accurate measures of illness duration and of readmission rates are made available.

The 30 per cent sample of April 1948 admissions totalled 1,621 individual veterans. In such stable characteristics as "Wars of Service" and "Service Connection" the composition of the sample is proportionately similar to routinely reported discharges and admissions.

Table 1 gives the distribution of admission diagnoses of these patients. Figure 1 indicates the percentage of the total number and the percentage of those in each diagnostic group continuously

Table 1. Admission Study Group (Unduplicated Persons)

Diagnostic class		Number
All diagnoses		1,621
Psychoses of unknown etiology	360	
Schizophrenia	303	
Affective	36	
Other	21	
Psychoses of organic or demonstrable etiology	125	
Alcoholic	54	
Senile, presenile, and arteriosclerotic	26	
Other	45	
Psychoneuroses	534	
Anxiety reactions	265	
Hysterical reactions	96	
Somatization reactions	82	
Depressive reactions	26	
Other	65	
Character and behavior disorders	282	
Alcoholic addiction	144	
Pathological, psychopathic and immat. pers.	113	
Other	25	
Neurological disorders	245	
Vascular	77	
Trauma	41	
Inflammatory	30	
Other	97	
Observation (mental)	75	

remaining in the hospital (solid line) or present in the hospital (dotted line) for the 25-month period. The dotted line indicates those readmitted as well as those remaining continuously.

Perhaps the most conspicuous and encouraging finding of the study is the high discharge rate of hospitalized veteran patients.

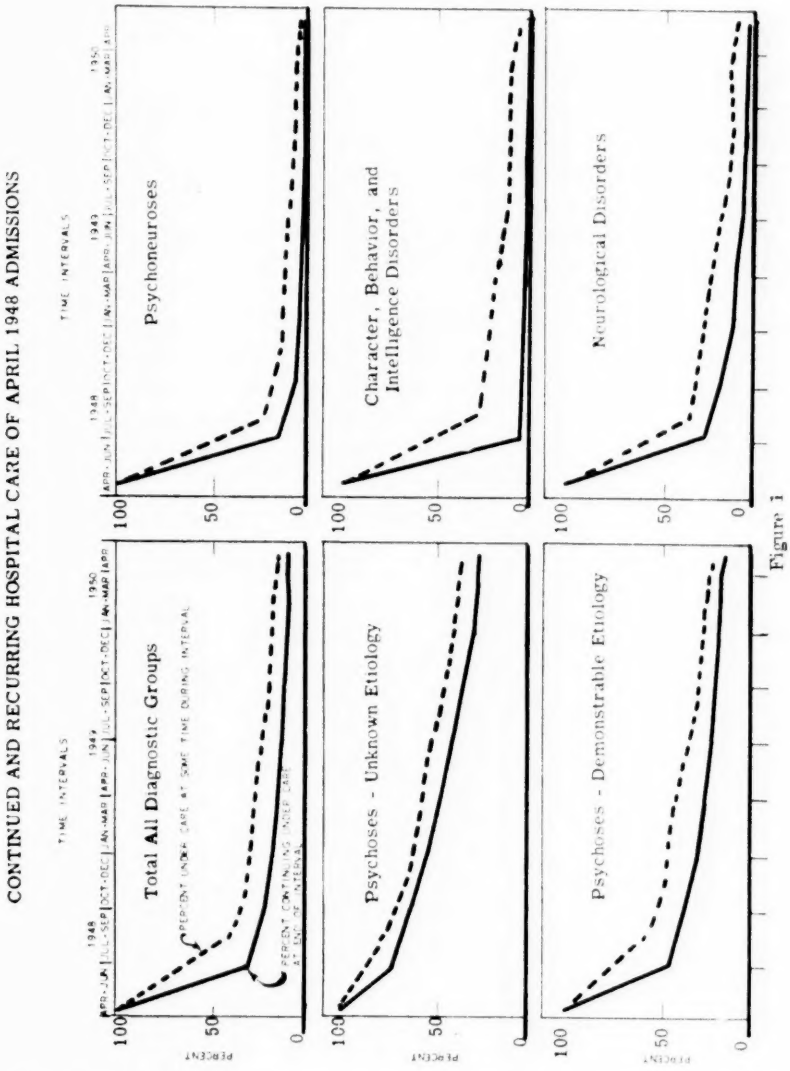

Figure 1

The least favorable discharge rate is with the psychoses of unknown etiology—predominantly schizophrenia. However, even there, only 27 per cent of the total group have had an uninterrupted hospitalization of 25 months, and only 36 per cent are in a veterans' hospital at the end of 25 months. From the psychoses of

known etiology, which in the writers' group are predominantly alcoholic, 13 per cent were continuously hospitalized for 25 months and 21 per cent were in a veterans' hospital at the end of 25 months. Next come the neurological disorders, with 5 per cent continuously hospitalized for the period and 11 per cent in a hospital at the end of the period. Of patients with character, behavior and intelligence disorders, only 1 per cent were hospitalized continuously for 25 months, and only 6 per cent were in a veterans' hospital at the end of 25 months. The psychoneuroses presented the most favorable outlook as regards hospitalization with only 0.4 per cent hospitalized continuously for 25 months and less than 4 per cent under veteran hospital care at the end of 25 months.

While the patients hospitalized at the end of 25 months in the psychotic group were preponderantly individuals who had remained in the hospital, those in the psychoneurotic and character disorder groups were preponderantly readmissions. It is noteworthy, however, that the rates of readmission of both of these groups dropped off substantially during the 25-month period. The rate of readmission of psychoneurotic patients dropped from 11 per cent of those on discharge status in the first three months of the study to about 5 per cent of those on discharge status at the end of the study, while the rate of readmission in the character disorders dropped from 24 per cent to 6 per cent in a like interval. The fact is conspicuous that although the readmission rate is relatively high for the character disorder group, it drops off rapidly with the passage of time.

Discharges against medical advice constitute 9.6 per cent of the total discharges. Discharges because of absence without official leave constitute 3.8 per cent. Discharges because of disorderly conduct constitute 0.9 per cent. These, together, are called irregular discharges and constitute 14.3 per cent of the total discharges. They are lowest for the patients with diagnoses of organic neurological disorders (8.4 per cent) and of psychoneuroses (8.8 per cent). Psychoses of organic or demonstrable etiology occupy an intermediary position (11.5 per cent). The ratios are high for the character and behavior disorders (16.4 per cent) and for the psychoses of unknown etiology (20.2 per cent), and highest of all for the small category, mental observation (49.6 per cent). This last may be partly an artefact in that some of the patients in this group may be so listed because they went out against advice with-

out remaining in the hospital long enough for the establishment of a diagnosis.

If one compares the percentage of individuals who, if they sought further hospitalization, always returned to the same hospital, with those who sought different hospitals there is an interesting parallelism to the rate of irregular discharge. This is revealed in Table 2. This table provides an index of the patient's confidence in the hospital. The following generalizations are suggested:

Table 2. Indices of Patient Morale

	Percentage of discharges irregular	Percentage of rehospitalized patients going to another hospital	Percentage of hospital readmissions to another hospital
Neurological disorders	8.4	25.6	20.1
Psychoneuroses	8.8	39.1	45.5
Psychoses of organic or demonstrable etiology	11.5	42.9	43.0
Character and behavior disorders	16.4	58.8	59.0
Psychoses of unknown etiology	20.2	55.1	61.5
Mental observation	48.7	70.6	65.8

1. Patient morale in these terms appears to be higher for those diagnoses in which the personality is well-preserved than for those diagnoses involving personality disintegration.

2. Patient morale appears to be higher for organic diagnoses than for non-organic diagnoses.

3. Patient morale appears to be higher for diagnoses of known etiology than for diagnoses of unknown etiology.

4. Patient morale appears to be higher for definite diagnoses than for indefinite diagnoses.

If one considers the stability of diagnosis on readmission in relation to the various diagnostic groups, the results are interesting. Table 3 compares the stability of diagnosis on next admission for three groups of psychiatric diagnoses on previous admission—schizophrenia, character and behavior disorders, and psychoneuroses. The stability of diagnosis is greatest with schizophrenia and least with the psychoneuroses.

Table 3. Relation of Admitting and Readmitting Diagnoses

Readmitting diagnoses	Schizophrenia (116 cases) Percentage	Psychoneurosis (237 cases) Percentage	Character and behavior disorders (234 cases) Percentage
Diagnoses other than neuropsychiatric..	4.3	37.5	28.6
Neurological disorders	0.0	2.5	4.7
Mental observation and ill-defined mental morbidity	5.2	3.4	3.8
Psychoneuroses	6.0	same type 19.4; other type 15.6	8.1
Character and behavior disorders	6.9	12.7	same type 32.5; other type 12.0
Psychoses ... Schizophrenia, same type	53.4	8.9	10.2
Psychoses ... Schizophrenia, other type	17.2		
Psychoses ... Other psychoses	6.9		

It should not be assumed that all changes are due to confusion in diagnoses. Only the principal diagnoses are compared here. No psychiatric diagnosis is a protection against acute appendicitis, for example, and if an ambulatory schizophrenic or a psychoneurotic is hospitalized for appendectomy he will be classified under a surgical primary diagnosis regardless of the persistence of his psychiatric condition and its recognition in a secondary diagnosis. Furthermore, a nonpsychiatric diagnosis may in fact be intimately related to a psychiatric one. If an alcoholic patient stumbles in front of a truck and comes back into the hospital with traumatic injuries, the incident may be a result of his addiction to alcohol. A gastric neurosis may result in organic changes in the gastrointestinal tract of sufficient clarity to justify an organic diagnosis on rehospitalization.

With these potentialities recognized, the fact remains that the psychoneuroses in particular have a conspicuous instability of diagnosis on rehospitalization and the character and behavior disorders are relatively unstable.

The writers have further examined the specific shifts of diagnosis on rehospitalization among 10 diagnostic categories. Some

consolidation of categories was necessary in order to have sufficient material to determine stability statistically. They selected the following categories:

1. Paranoid schizophrenia.
2. Schizophrenia other than paranoid.
3. Alcoholic psychosis.
4. Anxiety reaction without or with hysteria or somatization.
5. Hysterical reaction without anxiety.
6. Somatization reactions.
7. Other psychoneuroses (preponderantly hypochondriacal or depressive). This group will hereafter be called miscellaneous psychoneuroses.
8. A group of personality disorders made up of inadequate personality (49 diagnoses), emotionally unstable personality (31 diagnoses), dependency reaction (19 diagnoses), antisocial personality (17 diagnoses), and immaturity (1 diagnosis).
9. Alcoholic addiction.
10. Ill-defined mental morbidity.

These groupings were made on the basis of: (1) diagnostic similarity, and (2) the absence of evident dissimilarities in the patterns of diagnostic groupings to which they shifted on rehospitalization.

Having selected these 10 diagnostic classes, one can compare the frequency with which there are shifts from one to another on rehospitalization.

For example, the shift between the diagnosis of schizophrenia, paranoid type, and the diagnosis of alcoholic psychosis is revealed in Table 4. This table compares the diagnosis of paranoid schizophrenia and of alcoholic psychosis on prior and subsequent hospitalizations. There are 89 such comparisons of prior and subsequent admissions. In 45 instances the diagnosis on both hospitalizations was paranoid schizophrenia. In 39 the diagnosis was alcoholic psychosis on both hospitalizations. There were three instances in which on the prior hospitalization the diagnosis was paranoid schizophrenia and on the subsequent hospitalization it was alcoholic psychosis, and there were two instances in which

Table 4

Diagnosis on subsequent admission	Diagnosis on prior admission: Alcoholic psychosis	Diagnosis on prior admission: Paranoid schizophrenia
Paranoid schizophrenia	2	45
Alcoholic psychosis	39	3
		r= +.98
		k= +.19

the diagnosis on prior admission was alcoholic psychosis and on the subsequent admission was paranoid schizophrenia.

With this material, one can calculate the correlation between the diagnosis on prior hospitalization and the diagnosis on subsequent hospitalization. The writers used the tetrachoric correlation coefficient—in this case +.98. This represents a high degree of correspondence between the first diagnosis and the second diagnosis when the diagnosis of paranoid schizophrenia is compared with that of alcoholic psychosis. These diagnoses remain distinct and discrete on subsequent admissions, with little change or confusion. This high degree of consistency in diagnosis may be taken to indicate that these diagnostic categories are both well-defined and significantly different. If, on the other hand, one considers the stability of the diagnosis of psychoneurosis, anxiety reaction, as compared with the group of inadequate, emotionally unstable personality diagnoses, it is found that in 33 instances a patient was diagnosed anxiety reaction on both his prior and his subsequent hospitalizations, and in 44 instances he was diagnosed as falling in the inadequate, emotionally unstable personality group on both his prior and his subsequent hospitalizations (Table 5). Thus in a total of 77 cases the prior diagnosis was confirmed by the subse-

Table 5

Diagnosis on subsequent admission	Diagnosis on prior admissions: Anxiety reaction	Diagnosis on prior admissions: Inadequate, emotionally unstable personality group
Inadequate, emotionally unstable personality group	25	44
Anxiety reaction	33	20
		r= +.40
		k= +.92

quent diagnosis. There were, however, 25 instances in which the prior diagnosis was anxiety reaction and the subsequent diagnosis fell in the inadequate emotionally unstable personality group, and 20 instances in which the prior diagnosis fell in this group, and the subsequent diagnosis was anxiety neurosis, making a total of 45 instances in which the diagnosis changed from one group to the other. In this instance the correlation between diagnosis on prior and subsequent hospitalization was only +.40. This would indicate that the categories themselves are either not fundamentally separated, or else that their definition is not sufficiently good to establish an effective separation in their actual application. A correlation between first and second diagnosis of +1.00 would indicate a perfectly consistent diagnostic separation. A correlation of zero would indicate that purely random factors would account for such repetitions as appear. The range of correlations actually observed is from +1.00 down to +.40. To make an analysis of the interrelations of diagnoses, it is necessary to have an index of the resemblance between the different diagnostic categories. This was obtained from the correlation between successive diagnoses. For this purpose, the writers used k, the coefficient of alienation, defined statistically as $\sqrt{1 - r^2}$. A relation of purely chance consistency between prior and subsequent diagnosis would result in a k of +1.00 and a relation of perfect consistency would result in a k of 0.

The correlation coefficient of +.98 between successive diagnoses when alcoholic psychosis is related to paranoid schizophrenia is transformed into a coefficient of alienation of +.19, expressive of the resemblance of the diagnosis of alcoholic psychosis to the diagnosis of paranoid schizophrenia. The correlation coefficient between successive diagnoses of +.40 when anxiety reaction is compared with paranoid schizophrenia is transformed into an alienation coefficient of +.92, expressive of the resemblance in practice of the diagnosis anxiety reaction to the diagnoses in the inadequate, emotionally unstable personality group. This procedure made it possible to prepare a matrix of the intercorrelations of the 10 selected or grouped diagnoses which was subjected to factor analysis. The range of values of k in this table, which forms the correlation matrix, is from 0 to +.92, the latter factor reflecting a close similarity between the diagnoses of anxiety reaction and inadequate personality.

Factor analysis is a statistical process for determining the minimum number of independent factors which will make it possible to account for a table of intercorrelations. This table was subjected to a factor analysis by the centroid method and three factors were extracted. The centroid factors were then subjected to a process of rotation in order to arrive at a psychologically meaningful solution. In the solution arrived at, the three factors are, in geometrical terms, very slightly oblique, or, in statistical terms, are very slightly correlated, one with another. The factor loadings are listed in Table 6.

Table 6. Factor Analysis of Repeated Admission Diagnoses—Rotated Factor Matrix

Diagnosis	X	Y	Z	k^2
Schizophrenia, other than paranoid	.68	.01	.11	.51
Paranoid schizophrenia	.59	—.03	.11	.37
Miscellaneous psychoneuroses	.06	.80	.04	.75
Psychoneurosis, somatization reactions	—.02	.70	.10	.55
Anxiety reaction	.03	.83	.43	.99
Inadequate, emotionally unstable personality	—.02	.60	.45	.63
Hysterical reaction	.14	.27	.04	.13
Alcoholic addiction	—.05	.49	.65	.72
Alcoholic psychosis	.14	.00	.46	.78
Ill-defined mental morbidity	.30	.62	.60	.63

Factors		Correlation between primary vectors	
Schizophrenic factor	X	.X	Y
Psychoneurotic factor	Y	.31	
Factor of alcohol poisoning	Z	—.11	.06

The factor most sharply defined is obviously schizophrenia. The only specific diagnoses with substantial loadings on this factor are *paranoid schizophrenia* (+.59) and *schizophrenia, other than paranoid* (+.68). A third entry which does not really constitute a diagnosis also has a loading on this axis (+.30). This is the ambiguous entry, *ill-defined mental morbidity.* It is significant that the loading of this category on the schizophrenic axis is only half its loading on the other two axes. This is another fact which indicates there is less confusion on the schizophrenic axis than on either of the others.

Falling along the second axis are *psychoneurosis, somatization reactions* (+.70), *miscellaneous psychoneuroses,* (+.80) and, at a

lower level, *hysterical reaction without anxiety* (+.27). This axis seems clearly defined as a psychoneurotic axis.

The only diagnosis falling close to the third axis is *alcoholic psychosis*. However, the diagnosis with the largest loading is *alcoholic addiction*. This seems to be an axis which may be called alcohol poisoning.

The last column of Table 6 contains the unrotated common factor variance. It is an indication of the fraction of the total variance of each item which is accountable in terms of the loadings with the three factors. It is notable that while this analysis accounts quite adequately for the changes in diagnosis of such diagnoses as anxiety reaction, alcoholic psychosis and miscellaneous psychoneuroses, only a small fraction of the elements determining the diagnosis of hysterical reaction appears to have been captured in this study and there would appear to be large elements in paranoid schizophrenia which are not reflected in the factors isolated.

If this analysis be accepted, then the diagnoses may be divided interestingly in terms of the contribution of these three fundamental factors. This is depicted in Figure 2, which is a representation by the method of extended vectors.

In this figure, the centers of the three circles represent the points at which the axes of the three factors pass through the plane of the figure. Those diagnoses falling within a circle are affected by that factor and are practically unaffected by the other two factors. Those falling on lines connecting two circles are affected by these two factors, and the one falling within the triangle is affected by all three factors.

Paranoid schizophrenia and other schizophrenia fall close to a schizophrenic center. Somatization reactions and miscellaneous psychoneuroses fall close to a psychoneurotic center. Alcoholic psychosis falls close to a center for alcohol poisoning. The variability of all these diagnoses indicates a substantial loading with one of the factors and an absence of the other two. There is a series of three diagnoses clustered along a line from the center for alcohol poisoning to the psychoneurotic center. These are diagnoses with significant loadings on two factors. All represent elements of both psychoneurotic tendency and alcohol poisoning. The relative importance of the psychoneurotic element progressively diminishes and the relative importance of the element of alcohol poisoning progressively increases as one moves from anx-

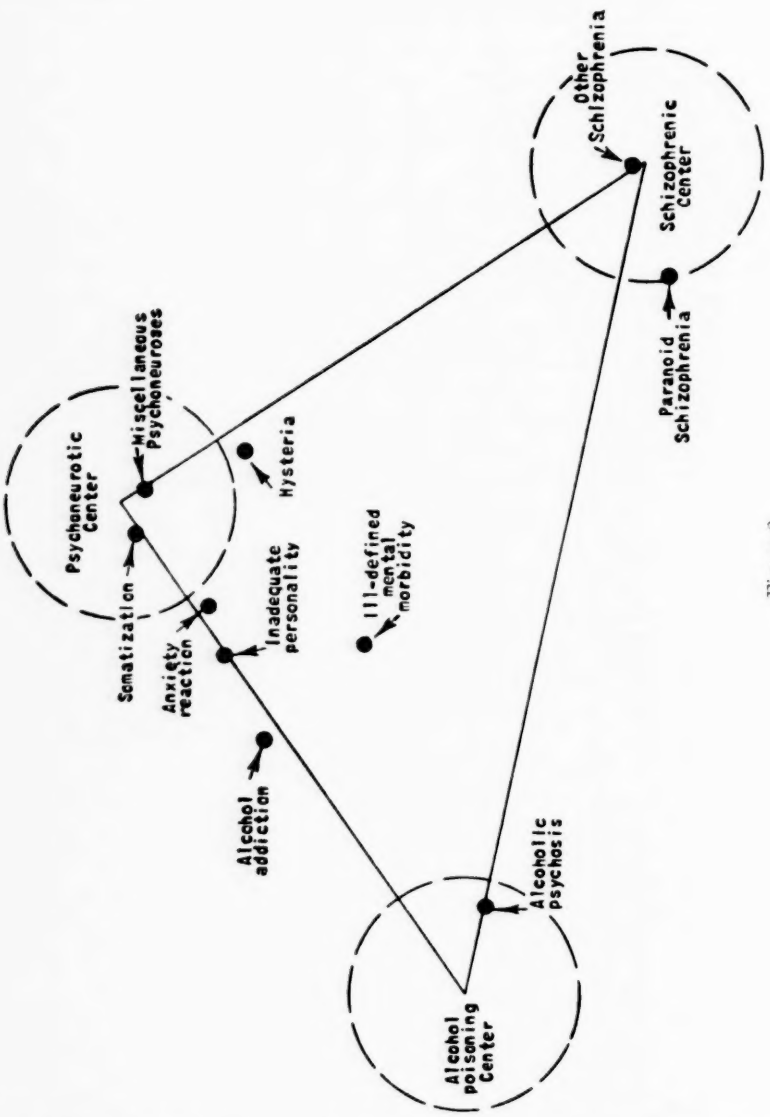

Figure 2

iety reaction to inadequate or emotionally unstable personality to alcoholic addiction.

It is of some interest that a count reveals that the shift from the diagnosis of alcoholic addiction to the diagnosis of inadequate,

emotionally immature personality occurs 48 times. The reverse shift occurs only 14 times. This suggests that the prominence of alcohol poisoning in these cases may recede at subsequent admissions over the two-year period, leaving a personality which is no longer diagnosed as alcoholic but which is diagnosed as inadequate or emotionally unstable.

The diagnosis of hysteria is outside the psychoneurotic center and has some leaning toward the schizophrenic factor.

The diagnosis of ill-defined mental morbidity is, as one might expect, well out in the middle of the triangle with substantial loadings on all factors.

Summary

While the group of psychoses of unknown etiology, predominantly composed of schizophrenic patients, has the lowest discharge rate of any of the groups studied, nevertheless only 36 per cent of the original patients were in a VA hospital after two years, and only 27 per cent had remained there continuously for that period. In this category, patient morale, as indicated by irregular discharges and by the tendency to seek another hospital for readmission, is understandably poor.

The hospital stay of both psychoneurotic patients and patients with character and behavior disorders is, almost without exception, brief, but the tendency toward readmission is rather strong, particularly with patients classified as having personality and behavior disorders. However, in a two-year period the monthly rate of rehospitalization for those of the psychoneurotic group currently on discharge status declines from 11 per cent to 5 per cent and for the character and behavior disorder group declines from 25 per cent to 6 per cent. This would suggest a rather pronounced tendency toward stabilization over a period of time. The stability of diagnosis in the psychoneurotic and in the character and behavior disorder groups is at low level, and patient morale is not good in the latter group.

Factor analysis of the changes between 10 diagnoses or diagnostic groups of diagnoses indicates three underlying factors which account for such changes. These are a schizophrenic factor, a psychoneurotic factor and a factor of alcohol poisoning.

Paranoid schizophrenia and other forms of schizophrenia share, as one might expect, the schizophrenic factor. Somatization re-

actions and what the writers had called miscellaneous psychoneuroses (predominantly hypochondriacal and depressive reactions) appear to be rather "pure culture" psychoneurotic reactions, dependent on the psychoneurotic factor. The writers ascribe the alcoholic psychosis essentially to the factor of alcohol poisoning.

The conditions described as anxiety reaction, inadequate and emotionally unstable personality, and alcoholic addiction, as used in Veterans Administration hospitals, are closely related diagnoses, having two important factors in common, a factor of psychoneurotic tendency and a factor of alcohol poisoning. The significance of the psychoneurotic factor diminishes, and the significance of the factor of alcohol poisoning increases as one progresses from anxiety reaction to the inadequate and emotionally unstable personality group, to alcoholic addiction.

Hysteria appears to be the most individual and distinctive of the psychoneurotic reactions considered, and appears to have a little more in common with schizophrenia than do the somatization reactions, the anxiety reactions, or the miscellaneous psychoneuroses.

As a word of caution, the writers would say that factor analysis makes it possible to discover common factors running through several different diagnoses. The elements distinctive of a single diagnosis, do not, of course, come out as factors; and, for a common factor to be brought out, it must, in fact, be common to more than one diagnosis. An approach based on only 10 diagnoses obviously cannot be exhaustive. Such an analysis is limited by the number of diagnoses included. There is certainly reason to believe, for example, that there are important factors in psychopathic personalities other than a psychoneurotic factor and a factor of alcohol poisoning. To determine these additional factors one would need a series of related diagnoses which, in this study, the authors did not have in sufficient number.

Veterans Administration
Central Office
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THE VALUE OF EARLY MEMORIES IN PSYCHOTHERAPY

BY RALPH J. KAHANA, M. D., J. HYMAN WEILAND, M. D., BENSON SNYDER, M. D., AND MILTON ROSENBAUM, M. D.*

In recent years there has been a good deal of interest in developing more efficient techniques of psychotherapy which are based on psychoanalytic concepts. Comprehensive planning of treatment in accordance with the needs of the patient has been considered an essential feature of such "brief psychoanalytic therapy."[1] To prepare a rational therapeutic plan the therapist must usually arrive at a meaningful psychodynamic formulation of the case at the beginning of treatment. One of the techniques that the writers have found useful in achieving early psychodynamic understanding is that of eliciting the earliest childhood memories of patients during the diagnostic period. Patients are asked directly for their earliest recollections during intake interviews, and in the exploratory phase of psychotherapy. In instances in which the patient gives only one memory, he is asked if there are any others; and further memories are usually elicited. In the dynamic understanding of these memories, attention is paid to the sequence and relationships of the memories as well as to the content. Any spontaneous comments (associations) on the memory are also noted and treated as part of the memory.

Early memories form a spectrum ranging from true and factual experiences to complete fantasy. Regardless of the validity of the content, the memories may help in understanding the dynamic structure of the personality. It must be stressed that early memories are of the greatest clinical usefulness when integrated in the total psychiatric anamnesis rather than treated as isolated phenomena. They often reflect the patient's principal unconscious conflicts, and may refer to emotionally traumatic childhood experiences, the patient's main ego defenses and at times to transference trends. When early memories are elicited during interviews with patients who are presented at graduate and undergraduate teaching seminars, they have provided valuable ready illustrations of psychodynamic patterns.

*The writers wish to express appreciation to Dr. I. Arthur Mirsky, Dr. Henry D. Lederer, Dr. Stanley L. Block and other senior staff members and junior house officers of the department of psychiatry, University of Cincinnati, College of Medicine, and Cincinnati General Hospital, for helpful critical suggestions and access to case material.

Review of the psychiatric literature of the past 30 years reveals only a few studies of earliest recollections. Most of these stem from Freud's elucidation of the concept of screen memories.[2] Freud observed that some earliest childhood recollections were of indifferent events that could not have produced any strong emotional effect. This contrasted with most adult and childhood memories which are of emotionally significant experiences. He reported an investigation of such an emotionally indifferent recollection and demonstrated that it was actually a screen memory representing a compromised expression of repressed instinctual wishes. Freud suggested that "screening" occurs to some extent in all childhood recollections, and believed that the essential emotional experiences of childhood are preserved in screen memories.[3]

Rapaport[4] notes that the contribution of psychoanalysis to the theory of memory concerns forgetting or the non-emergence into consciousness through repression; the mechanisms encountered in the analysis of forgetting are the same that perform the dream work and these constitute specific memory functions. It might thus appear theoretically correct to analyze earliest memory in the same manner as dreams. However it must be recognized that the dream occurs in light sleep when ego control is weakened, whereas the earliest memory is produced by the awake individual in a setting of stronger ego control. It is possible therefore that different information is obtained from early memories than from dreams.

Several psychological investigations of the manifest content of earliest memories have been conducted in groups of "normal" adults and children.[5, 6] These studies reveal that the majority of earliest memories were of unpleasant experiences. Blonsky[6] cites Adler as having indicated that the earliest memory gives a picture of how the patient solves important life problems. Adler believed that the earliest memory provided a simple way of uncovering the feelings of inferiority which he held to be of basic importance. Stern[7] reported the usefulness of early memories in understanding the dynamics of children with psychiatric illnesses.

Schachtel[8] defines memory as a function of the living personality which can be understood only as a capacity for the organization and reconstruction of past experiences and impressions in the service of present needs, fears and interests. This definition emphasizes the close relationship between current personality functioning and the memory picture which an individual retains of

past experience. However, in stating that the present shapes our view of the past, the definition neglects the effect of past experience in determining present needs, fears and interests. Earliest memories are an organic part of the personality and, as such, reflect total personality functioning.

The following case abstracts illustrate various kinds of meaningful information found in early memories.

Case 1

This is a verified screen memory demonstrating a childhood trauma.[9]

A 53-year-old, white, married man had suffered from attacks of anxiety and claustrophobia for 30 years. The first attack took place while the patient was on a business trip with an older man shortly after his marriage. The patient was shocked and frightened when the older man suggested that they pick up two girls. Subsequently attacks occurred in such specific settings as when he was in a berth on the train and when a barber placed a towel over his nose preparatory to shaving him. A recent attack occurred after a doctor had packed his nose with penicillin.

The patient was a successful and self-made business man with obvious pseudo-masculine character traits. He bragged of his prowess not only as an athlete but also as an engineer, despite lack of formal education. He had invented numerous gadgets and for some years had been engaged in working seriously on a perpetual motion machine.

Shortly after his marriage, sexual difficulties appeared. His wife was frigid and very inhibited sexually. He asserted that in 30 years there were only 10 or 15 marital sexual experiences. He considered himself to be "oversexed" and in the past 10 years had been living with an attractive younger woman with whom he enjoyed sex. He had kept up his home for social appearances, and his wife and sons knew and accepted this arrangement.

When the patient was asked of his first awareness of sex he told of masturbating at the age of four or five and engaging in sex play with many little girls. He vigorously denied any traumatic experiences associated with early sexual behavior. The therapist was immediately struck by the unusual clarity and lack of anxiety associated with this early sexual material and felt that the ease with which this material came out indicated that the patient had a

strong need to deny childhood sexual traumatic incidents and was utilizing the early sexual memories as a cover. An attempt was made to shorten the psychotherapy by the use of a sodium pentothal interview.

This interview was sterile until the very end, when the patient was asked to give his first memory. Prior to this time, he had insisted that there were no unpleasant memories and no fears during childhood. He then mentioned an accident, occurring at about the age of four or five, in which his nose had been broken. This recollection was followed by another, from the age of five or six, in which his father had slaughtered his pet pigeon, which he had had since he could remember. The bird was five or six years old when his father had killed it by cutting its throat in front of him. Later the family ate the bird. He denied that he was frightened by this experience, but cautiously admitted that he was a bit angry at his father. He then spoke of fear of birds, revealing that he could not handle a bird because he could not stand the warm, soft, wriggling body in his hand; and he admitted he still became extremely frightened if a bird happened to fly into his house. He mentioned how fond he had been of his pet pigeon and how he had loved to fondle it and do tricks with it. At this time it was noted that the patient's hands gradually shifted so that they covered his genitals, and he was allowed to wake up. When awakened, he expressed the desire to urinate.

The patient insisted that the memory was true despite the fact that collateral history from an older sister revealed that the pigeon had belonged to the father and had died a natural death. In the next interview, the patient recalled memories in which his father had threatened him for masturbating and sex play, and then remembered that his father had tied his hands to his bed at night to prevent masturbation.

Comment. The early memories of childhood sexual activity represented a denial of the underlying intense castration anxiety. The early memories obtained in the pentothal interview were screen memories for castration anxiety, as revealed in the memories, recovered later, concerning masturbation threats by the father. His attempts to master the anxiety associated with these childhood traumata not only led to his neurosis but also were a determining factor in the development of his pseudo-masculine character structure.

Case 2

Early memories of a 24-year-old, white, married woman suffering from Raynaud's disease indicated her principal emotional conflicts and some of her ego defenses.

1. She recalled being forced at five years of age to sit in kindergarten with her hands clasped together as a punishment for general classroom unruliness. She clenched her hands so tightly that her fingers turned white, and her woman teacher was alarmed.

2. In early childhood, her mother would not allow her to help in the kitchen, because she was "so clumsy" with her hands.

3. When she was five the patient and her younger sister were playing with a boy cousin. He suggested that they exhibit themselves to each other. The patient and her sister refused. He proceeded to exhibit himself and was spanked by the patient's mother and his own mother.

These memories depict a situation in which the patient is punished by a parent figure (the school teacher) for an occurrence in which she is minimally to blame (general unruliness in the class). She reacts by suppressing her hostility, further punishing herself by clenching her hands, and simultaneously punishing and gaining the attention of the teacher (alarming her). The patient then indicates that her mother depreciated her, would not allow her to compete as a woman (help out in the kitchen), and felt that she did not use her hands properly (suggestive of forbidden masturbatory play). She finally shows that she feared mother's punishment for sexual wishes associated with exhibitionism. The boy in the final recollection is depicted as being punished for forbidden sexual activity. In both the first and third memories, the patient displaces blame from herself to others.

The patient had had frequent attacks of Raynaud's disease, in which her fingers became blanched and severely painful, for four years. The background of the onset of this illness reflects her sexually-motivated, competitive hostility to mother figures, and her reactive fear and self-punishment. Shortly before her first attack, the patient felt extremely resentful because her mother-in-law "had invited herself along" on a visit to the patient's husband in an army camp, and the husband had been more attentive to his mother than to her. After her return home, she had revenge fantasies of having extramarital sexual relations and her first attack began when she had an opportunity to do this. This and other at-

tacks served the purpose of preventing sexual acting out, but allowed expression of hostility and self-punishment. The patient had self-depreciatory, masochistic behavior patterns, sexual frigidity and much concern about exhibiting herself in public. Her main defense was one of regression from meeting adult emotional problems to a childhood conflict involving masturbatory impulses and hostility to both parents.

Case 3

An early memory of a 29-year-old man with conversion hysteria indicates the early patterning of his present behavior.

At the age of eight or nine, he wanted to play the violin and kept weeping to his parents for one. "When I got one, I quit playing after three lessons. I quit easily, I'm just not a fighter."

The patient sought treatment for episodic headaches and anxiety. These were readily seen to follow life situations that would be expected to evoke annoyance or anger. He was usually unable to express these affects, although aware of them. However, he was not aware of the linkage between his symptoms and unexpressed hostility. The early memory gives a hint that the patient tends to give up in the face of obstacles ("I quit . . . after three lessons") and clearly indicates his need to present himself as one who does not succeed. He further equates success with fighting (". . . not a fighter"). For these reasons, he avoided aggressiveness and success, because of his fear of hurting others, being hurt, or both.

Since rhythmic motion, such as playing the violin, often symbolizes masturbation or other genital activity, one suspects that this patient's problems also relate to conflicts about genital sexuality. This was borne out in the course of therapy when he complained of impotence and premature ejaculations. A graphic validation of the foregoing interpretations, is presented in the following episode of the patient's current life. During the course of therapy he married. On the first night of the honeymoon, intercourse was successful despite difficulty in effecting entrance. Successful intercourse was attained on the next two occasions, but he became somewhat anxious on the third night when his wife pointed out the presence of some bleeding and pieces of the torn hymen. Following this, he was unable to maintain an erection beyond the stage of foreplay unless he placed himself in the supine position with his wife above.

In addition to these leads to the patient's conflict and his modes of meeting them, one can suspect certain transference manifestations. He said he was "not a fighter" and presented himself throughout the therapy as demeaned and unsuccessful even though he had built up a thriving business. He had been passively compliant and denied any hostility toward the therapist while expressing a great deal by innuendo.

Case 4

An early memory sequence indicates regression from the genital level of libido organization in a neurotic character.

A 32-year-old, married, white man came for treatment because of work inhibitions. In the course of therapy, it became clear that his dependency needs were a defense against anxiety connected with sexuality.

His two early memories were as follows: 1. He remembered having had a birthday party at the age of three, at which he ate ice cream and cake. 2. At the age of four, he got into a fight with a a group of boys, was struck on the head and ran home to his mother bleeding from his scalp.

These two memories depict in reverse order regression to oral dependency resulting from fears of aggressive competitive masculinity. Conflicts centering around this area of his life were the core of his neurosis.

Case 5

Early memories of a middle-aged professional man suffering from a peptic ulcer illustrate oral fixation and intense sibling rivalry.

The early memories were: 1. The patient was told that as an infant he was removed from his mother's breast because the breasts dried up. He was placed on a bottle, began to lose weight and was dying when his aunt discovered that the rubber nipples on the bottles were stopped up. 2. He recalls that when he was six, his next youngest brother, who was five, died. 3. He and a younger brother were lost and the younger brother was crying. The patient comforted him. 4. At the age of nine while on a ship coming to this country from Europe he hurt another younger brother when he pushed him off a chair.

This patient was first seen during a stage of panic with paranoid features, at a time when his wife threatened to divorce him.

The patient was pathologically jealous of his wife, was extremely possessive of her, and was resentful of any interest that she showed in anyone besides himself. His ulcer symptoms had started 10 years previously, during a time in which he was separated from his wife for a month while she was on a vacation. When he joined her, he asserted that she rejected him for two young male cousins with whom she spent all her time sailing. During a long course of psychotherapy in which a strong dependent transference was established, the patient weathered a divorce from his wife, recovered from his ulcer symptoms and made a good all-around adjustment.

The patient's basic oral fixation, with its resulting frustration, and intense hostility toward his mother (which later revealed itself in paranoid-like attitudes toward his wife) was disclosed in his first early memory, in which he depicted himself as almost dying as a result of the mother's neglect. The second and fourth memories illustrate his hostility to younger siblings, and, in the third memory, he not only disguises hostility toward a younger sibling but disguises his own deep wish to be cared for by representing himself in a maternal role toward the hated younger sibling.

Case 6

An earliest memory of a 20-year-old, single, white woman with conversion hysteria indicated an important transference tendency.

During the fourth psychiatric interview, the patient was asked to tell her earliest memory of her father. She recalled that when she was seven years old she would provoke his anger by not wanting to go to school. She would cry and not want to get dressed. Her father would become so irritated and upset by her activity that he would be unable to eat breakfast and would have to leave for work without it.

During the first five months of psychotherapy, the patient blocked attempts to get an anamnesis by remaining evasive and unspontaneous. She frequently cancelled appointments, came in late, and, on one occasion, arrived with an attack of laryngitis that prevented her from speaking. More recently she has progressed to a teasing, provocative attitude in which she will say that she has

many things to tell the psychiatrist but cannot bring herself to do this. The positive elements of transference appeared in some disguised seductive behavior and, more clearly, when the patient learned that her therapist might have to leave for military service. She failed to keep the next three appointments, had an amnesia for an interpretation of what this loss of a supporting figure might mean to her, and then expressed the feeling that the therapist did not believe that her symptoms were real.

The therapist had to contend with initial counter-transference feelings of frustration, although they never quite reached the point where his breakfast was spoiled.

Summary

In recent years, it has been a routine practice in the psychiatric and psychosomatic clinics and wards of the Cincinnati General Hospital to ask patients directly for their earliest childhood memories. It has been the writers' experience that—when the memories are analyzed within a psychoanalytic conceptual framework—they may provide meaningful information about unconscious conflicts, significant traumatic experiences in childhood, defenses against anxiety and transference reactions. Although such data can be obtained in other ways, it is often promptly available in the earliest memories and thus helpful in the early formulation of a case. Case material illustrating the utility of the earliest memory is presented.

This communication is the initial report of a more extensive clinical study of earliest memories.

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A PRELIMINARY STUDY ON THE USE OF FLAXEDIL*

(*Gallamine Triethiodide*) (*Tri-(diethylaminoethoxy) benzene trioethyliodide*)

BY J. F. NEANDER, M. D., AND S. P. ALEXANDER, M. D.

Twelve years have elapsed since electric convulsive therapy was introduced in this country at the Pennsylvania Hospital. At the present time, it is a widely used, accepted procedure and the prevention of complications in its application is of great importance.

In a preliminary study using "Flaxedil," a new muscle-relaxing agent in electric shock therapy, a series of 13 patients with varying disabilities was chosen. These patients would ordinarily have received curare (d-tubocurarine, the active alkaloid of curare).

The most frequent complication of electric convulsive therapy is a fracture in the skeletal system, caused primarily by sudden contraction of muscles and deficiency in bone structure, as well as by faulty technique in application. In epilepsy, the tonic phase is much longer than in artificially induced convulsions, and this may explain why fractures are less frequent in epileptics.

Various measures have been introduced to minimize fractures. Von Braunmuhl treated patients in the embryo-like position, with little significant result. Some observers doubt whether the position of the patient plays an important role. Other attempts to reduce fractures included the use of magnesium sulfate, quinine metachloride, sodium amytal, glucose, dilantin, bromides, and calcium. Electric convulsive therapy with glissando attachment should theoretically reduce fractures because of less sudden onset of the tonic stage, but the experience of the writers during the past two years of using the glissando, does not substantiate this theory.

In 1940, Bennett reported on the use of curare, which has, at this time, become the accepted method for the prevention of fractures in electric convulsive therapy. This drug has been extremely useful in treating patients with bony deformities, recent fractures and cardiac deficiencies. Curare blocks the transmission of impulses across the myoneural junction in voluntary muscles, thus inhibiting the intensity of muscular contraction. In electric con-

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vulsive therapy, the dosage is regulated so as not to paralyze all the muscles completely, but rather to decrease the strength of the contractions. Curare has been accepted as an excellent muscle-relaxing agent but, at the same time, many psychiatrists have reported unfavorable side effects and fatalities that are primarily due to the drug. In reviewing the earlier material of Rockland (N. Y.) State Hospital, there were two recorded fatalities in curare-treated, electric convulsive therapy patients. The side effects, which usually are not serious but rather unpleasant, were: (1) respiratory embarrassment, requiring oxygen as a routine procedure; (2) a feeling of being paralyzed, accompanied by anxiety and resentment on the part of the patient after treatment; and (3) thrombosis of veins, an important complication in patients with poor veins.

In an effort to find a suitable substitute with effective muscular relaxation but without these complications, the authors are now using a new substance, "Flaxedil (Gallamine triethiodide)," which was synthesized in France by Rhône-Poulenc-Spécia. Patients who were to receive flaxedil were given the routine pre-electric-convulsive-therapy work-up, including thorough physical examination, dorsal spine x-rays, EKG and any other elective tests. A test dose of 1 cc. of flaxedil was given intravenously, over a period of one minute, the cubital vein having been used routinely. The patients were told they were receiving a muscle-relaxing drug which would have a short period of action, following which they would receive a second injection to neutralize the first, after which they would be put to sleep. After a period of three to four minutes, during which pulse, respiration and subjective symptoms were noted, an injection of 1 cc. of prostigmin was given by hypodermic. On the second day, a dose of 1½ to 2½ ccs. of flaxedil was given. According to the investigators, the theoretical initial dose of flaxedil tends to be 1 mgm. per kilogram of body weight. The fatal dose is 5.5 mgm. per kilogram of body weight. One cubic centimeter of flaxedil contains 20 mgms.; therefore about 3 to 4 ccs. should be given to an average person—but in the experience of the writers, a reduced grand mal seizure was obtained from dosages of 1.5 to 2.5 ccs. of flaxedil. Flaxedil is injected at a uniform rate of 1 cc. a minute.

The procedure just outlined, with tests for relaxation, such as asking a patient to raise and lower his head, open and close his

fists, and raise his body from a supine to the sitting position, was followed. In general, good relaxation occurred between one and one-half and three minutes, beginning with the eyelids, the masticator muscles, the musculature of the upper and lower limbs, and the abdominal muscles. The hand grip became weakened, and inability to rise to the sitting position quickly followed. At this time, an injection of 1 cc. of prostigmin by hypo and an application of ECT were given. The ECT stimulus was given in the same manner as unmodified ECT. The grand mal convulsion was definitely reduced in intensity, and the patients breathed spontaneously after cessation of the clonic movements. Oxygen was available but was required only about six times in over 170 treatments. This was in marked contrast to the experience of the authors when curare was used. It was routine practice to use oxygen with curare, because of extreme cyanosis.

Each electric shock treatment with flaxedil requires from six to eight minutes, from the beginning of the injection until the patient is returned to the recovery room. The patient is able to sit up about 20 minutes after the treatment and is able to return to his ward about 30 minutes later. Of the 13 patients treated, in this series with flaxedil-modified ECT, nine were males, four females. The youngest was 32; the oldest, 55. For physical contraindications to unmodified ECT, see Table 1. As is seen from the table, two patients had fractures of the scapula; though this condition is described as rare, it has not been so rare in the writers' experience. The psychiatric diagnoses and results are given in Table 2.

Table 1. Physical Contraindications to Unmodified ECT of Patients Treated with ECT and Flaxedil

Spine fracture, fresh	2
Spine fracture, healed	5
Severe spine deformity	1
Jaw pathology	1
Scapula fracture, fresh	1
Scapula fracture, healed	1
Congenital dislocation of both hips	2

Complications

There were no complaints of complete paralysis on the part of patients in this series. They did complain of weakness, together with some anxiety. This anxiety could usually be allayed, however, by reassurance and by the effectiveness of prostigmin dur-

Table 2. Results of Treatment with ECT and Flaxedil

Diagnosis	Recovered	Much improved	Improved	Unimproved	Total
Manic-depressive, depressed...	1	1	..	..	2
D. P. P.	1	1	1	..	3
D. P. C.	..	1	..	1	2
D. P. M.	..	1	1	..	2
Involutional paranoid	..	1	1	..	2
Involutional melancholia	..	..	1	..	1
Involutional, mixed	..	..	..	1	1
Total	2	5	4	2	13

ing the test dose. There were no falls in blood pressure after injection of flaxedil, and in a few instances a moderate rise in blood pressure was noted. Thrombosis of veins did not occur, and respiratory embarrassment following ECT occurred in only one case.

This cardiorespiratory collapse, which occurred in a 46-year-old, white man, has been the only serious complication encountered by the authors, to date. This patient, who had a history of a mitral valvular involvement, with myocardial damage as evidenced by the EKG, had suffered from rheumatic heart disease in childhood and had had a "heart attack," according to the family, two years before admission to the hospital. On admission, his mental condition was such that he required immediate ECT, which was given with a full realization of the risk involved. He received 10 electric convulsive therapy treatments, preceded in each case by 2 ccs. of flaxedil, with no difficulties aside from the occasional use of oxygen for a brief period after the convulsion. During the eleventh treatment, which was carried out in exactly the same manner as the preceding 10, the patient developed severe cardiorespiratory collapse, with cessation of breathing; rapid, thready pulse; and severe cyanosis. He received immediate supportive treatment, including oxygen, additional prostigmin, and coramine intravenously. EKG studies before and after this incident, showed no change. Further treatments were discontinued in this case, since the patient had shown much improvement in his mental condition, and it was felt that the case did not warrant further risk. It was felt by one of the writers (S. A.), who gave the treatment and observed the immediate reactions, that the cause was not the flaxedil alone, but rather a cardiac condition which had been present for many years. This was

felt to be the case, since in previous injections of flaxedil, there were no serious cardiorespiratory difficulties. The blood pressure variations, patients' behavior, type of convulsion, change in blood picture and pathology for which patients were treated, are best illustrated by the figures recorded before, during and after treatments (Table 3).

Conclusions

From the foregoing, the authors conclude that the "curarizing" effect of flaxedil is identical qualitatively with that of d-tubocurarine. Both act to block the transmission of impulses across the myoneural junction. Flaxedil has no consistent effect on the central nervous system, upon pain thresholds or upon synaptic transmission in the spinal cord, and does not affect sympathetic ganglia. Flaxedil does not have any effect upon the parenchymatous tissues of the viscera, or impede liver metabolism or urinary excretion, and has no apparent effect upon the uterus, intestines or myocardium. Flaxedil does not diminish blood pressure, vascular tone or myocardial activity, and therefore does not produce rapid vascular collapse such as may be seen following d-tubocurarine. Flaxedil has no histamine-like action. The fatal dose of flaxedil for the rabbit is 500 times greater than the customary curarizing dose. Flaxedil produced no thrombosis, and accidental peravenous injection caused no irritation.

The authors feel that preliminary studies indicate that flaxedil is a very valuable aid in ECT and is a safe substitute for d-tubocurarine. They are continuing to use it as a substitute because of the lessened toxic and unpleasant side-effects, as compared with curare.

Summary

Thirteen patients receiving modified ECT for structural reasons, were given flaxedil to obtain reduced grand mal seizures. A dosage of 1.5 to 2.5 ccs. was found adequate to modify the convulsion; the therapeutic effect of ECT, using the technique outlined in this report, was not interfered with by flaxedil.

Acknowledgment

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Table 3. Individual Treatment Data

Patient	Age	Did patient complain of feelings of paralysis?	Pulse before and after injection, treatment	B/P before and after injection, treatment	Cyanosis	Type of convulsions	Blood picture	X ray (pathology)	Headache
1. C. C.	33	No	100.120.110	150/100 160/110 160/100	No	Mild	Normal	No change	None
2. C. J. F.	29	No	92.108.110	118/62 112/58 115/60	No	Mild	Normal	No change	None
3. G. A. N.	23	No	90.100.105	120/70 115/65 115/60	No	Mild	Normal	No change	None
4. M. A. N.	55	No	88.100.105	115/75 120/70 125/80	No	Mild	Normal	No change	None
5. S. L.	47	No	90.100.100	125/75 130/80 130/85	No	Mild	Normal	No change	None
6. E. H. F.	47	No	108.124.120	140/80 145/80 140/80	No	Mild	Normal	No change	None
7. G. H.	46	Occ.	88.116.120	150/85 150/95 150/90	No	Mild	Normal	No change	None
8. C. C.	33	No	100.120.110	150/100 165/110 160/100	No	Mild	Normal	No change	Occ.
9. P. A.	41	No	96.116.116	125/80 120/80 130/80	No	Mild	Normal	No change	None
10. B.	35	Occ.	95.105.100	150/100 135/80 155/80	No	Mild	Normal	No change	None
11. O. S.	32	No	90.110.100	125/80 130/80 120/80	No	Mild	Normal	No change	None
12. H. W.	42	No	92.106.120	150/95 150/95 175/100	No	Mild	Normal	No change	None
13. B. J.	49	No	100.110.100	150/90 160/100 170/110	No	Mild	Normal	No change	Occ.

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FAMILY SETTING AND THE SOCIAL ECOLOGY OF SCHIZOPHRENIA

BY DONALD L. GERARD, M. D., AND LESTER G. HOUSTON, M. S.

This paper reports the results of an investigation into the social ecology of male schizophrenics in Worcester, Mass. Prior studies[1] have substantiated the findings of Faris and Dunham's well-known study, *Mental Disorders in Urban Areas*.[2] These studies have shown that:

(a) There are striking differences in the characteristics of different areas of a city. Extreme "disorganization," in terms of poor housing, delinquency, vice, infant mortality, tuberculosis rates, etc., is most evident in the central areas of large cities, that is, in the central business district and the surrounding slum areas. This disorganization decreases in gradient fashion toward the more stable, well-organized, peripheral suburban areas. "This pattern is not planned or intended and to a certain extent resists control by planning."[3]

(b) The rates of first admissions diagnosed as schizophrenia to public mental hospitals are highest in the central areas of the city and diminish in gradient fashion toward the suburban areas.

(c) Thus, the rates of schizophrenia fit into the ecological structure of the city. This suggests that the distribution of schizophrenia rates "is a function of the city's growth and expansion, and more specifically of certain undetermined types of processes."[4]

The fact that, in general, the rates are higher in areas of the city which are plausibly worse to live in, has been interpreted to mean that schizophrenia is enhanced, precipitated or somehow significantly influenced by these conditions of living. A corollary of this point of view is expressed rather succinctly in the following quotation. "Community 8A, the Gold Coast on the Lake front is an area settled by large hotels, inhabited primarily by the wealthy. The lack of serious social problems in this area is reflected in the low rate of all types of psychoses."[5]

Faris has suggested that there is a greater tendency for people reared in slum areas to develop schizophrenia. He says,[6] "there is a tradition of toughness among juveniles in these areas which makes more difficult the assimilation of children with egocentric and infantile traits into play groups and normal social living. In the more stable residential neighborhoods or in the suburbs, there may be a greater availability of sympathetic playmates and a

higher degree of parental and neighborhood cooperation which eases the process of assimilation of the spoiled child into play groups with other children." However, there is no explicit evidence that the slum areas of the city present the relevant background factors for schizophrenia[7, 8] to a greater degree than do the suburbs. It would be plausible to argue that egocentric and infantile traits are harder to maintain in the slums, and are particularly enhanced for the children of the well-to-do suburban families with restricted play groups, governesses, etc. If the statistics of rates were reversed, if maximal rates occurred in the suburbs and minimal rates in the slums, undoubtedly such a plausible explanation would be seriously proposed.

This discussion is intended to emphasize that the relationships between the hospitalization rates and the condition of social living in a given area have not been clarified. From the standpoint of understanding the pathogenesis of schizophrenia, it would be useful to understand the factors which are responsible for the rather well confirmed "typical ecological distribution" of the schizophrenia rates. The present investigation was oriented toward evaluating the role of two possible determinants of this pattern.

(a) The mode of living of the patient at the time of his overt disturbance which led to hospitalization—in terms of the family setting in which he was living at this time.

(b) Residential instability.

Correlative to this, a study of residence distribution was made to determine whether the typical ecological patterning of schizophrenia rates occurred in Worcester, Mass.

Methods

The subjects for this study were 305 male schizophrenics who were admitted to Worcester (Mass.) State Hospital from a residence in Worcester between 1931 and 1950. These patients were living in Worcester at the time their symptomatologies became overt enough to precipitate hospitalization. All mentally ill patients from Worcester (with the exception of those sent to private hospitals) are sent for observation and/or commitment to Worcester State Hospital. The subjects for this study were culled from the central diagnostic files and the yearly admission diagnostic records. Nativity, age at admission, diagnosis, residence,

and family setting (see following) were obtained from the face sheet (the first sheet of the patients' clinical folder) and checked with material in the psychiatric and social case study records.

Data

1. *Mode of Social Living*

The patients were categorized in terms of the home settings in which they were living when they showed symptoms of sufficient severity to warrant hospitalization. The categories used were: (a) Parental—living in the setting of the parental home. (b) Marital—living in the setting of the patient's own marital family home. (c) Sibling—living with siblings. (d) Single—living alone, unmarried, out of any family setting. (e) Divorced—living alone, divorced or separated out of any family setting.

It is emphasized that "single" and "divorced" do not pertain to marital status alone. Divorced or separated persons living with parents or siblings are categorized in the "parental" and "sibling" groups. "Parental," "marital" and "sibling" may be grouped together as "in a family setting"; "single" and "divorced" may be grouped together as "out of family setting."

This classification is adopted out of both psychiatric and sociological considerations. The location of a person's residence is partially dependent upon the type of family setting in which he is living.[9] On the other hand, the family setting of the schizophrenic has a meaningful relationship to his personality development and adjustment to his psychopathology in terms of the following conceptual framework:

Schizophrenia is a syndrome in which growing out of the parental family into adult independent social living is a crucial problem. In clinical experience it has been observed that male schizophrenics usually become acutely disturbed while immersed in prolonged daily interactions within their anxiety-productive parental situations. Some schizophrenics get out of this parental setting by developing an isolated social existence in which antagonistic, resentful feelings and relationships enhance their dissociation. A few schizophrenics are able to achieve, at least temporarily, conventional successful movement out of the parental home. They marry and form new family settings. Of these, some maintain at least superficially satisfactory relationships up to and after their breakdowns. Others of this group sever their marriage relation-

ships prior to manifest disturbance. These either return to close association with significant figures of the parental family, most usually with the mother, or they join the dissociated single group.

2. *Residential Instability*

In order to evaluate the role of residential instability or mobility, residence histories were obtained from social case material in the clinical charts, supplemented by interview and/or correspondence with patients, ex-patients or their relatives. Residence histories were obtained for 146 of the 305 cases. In order to evaluate possible bias in the residence history sample, diagnosis, nativity, age at time of first admission, and family setting of the group of cases with residence histories and those without residence histories were compared. As there were no significant differences in these important variables, the residence history sample can meaningfully represent the total study population (Table 1). The data were organized in the following categories—both for one year and

Table 1. Patients with Residence Histories Compared with the Patients without Residence Histories in Family Settings, Types of Schizophrenia, Ages at Times of First Admissions and in Their Nativities

Family setting	Residence history group Percentages	Without residence histories Percentages
Living alone	23	19
Parental	60	56
Marital	14	19
Sibling	3	6
Type of schizophrenia		
Paranoid	30	34
Catatonic	22	16
Hebephrenic	13	6
Simple	9	7
"Other types"	21	29
Undetermined	5	7
Ages at times of first admission	Years	Years
Living alone	32.2	34.1
Parental	25.0	25.2
Marital	35.8	34.5
Sibling	34.7	34
Nativity	Percentages	Percentages
Foreign born	17	14
Native born of a foreign-born parent	54	57
Native born of native-born parents	28	29

five years before admission: (a) Residence same as at admission. (b) Residence in Worcester but not at the same address as at admission. (c) Not in Worcester.

The residence at birth was categorized simply as "born in Worcester" and "not born in Worcester."

Finally, a map showing the Worcester residence of each subject was made. These maps were used to determine whether the several residences were in the same areas of the city or in areas with similar general living conditions (see following).

3. *Population and Housing Data*

Data on population and housing were obtained from a study reported and published by the Worcester Recreation Committee.[10]

Housing conditions. The wards of the city were divided into 25 zones, and an overall rating of favorability in regard to housing was assigned to each of them. This rating was a composite of four indices which are: (1) Rent. (2) Lack of bath or need of major repairs. (3) Number of dwelling units per structure. (4) Percentage of units owner-occupied.

These 25 subdivisions each received a qualitative rating, highest, high, average, low, lowest. These five ratings of favorability of housing were assigned consecutive numerical values for the purpose of this study, from 5 for highest favorability to one for the lowest. It is assumed here that the quality of housing gives a fair presentation of general social conditions[11]* for the different subdivisions of the city. Interestingly, the housing pattern of Worcester almost perfectly follows the "typical ecological pattern."[12] The ward divisions in the one-mile zone had the lowest ratings, in the two-mile zones, low or average ratings and in the three-mile and four-mile zones high and highest ratings. As the present writers' data are collected by wards, a composite index of each ward was obtained by taking the sum of the products of each ward subdivision housing rating and its population and dividing by the total

*As an example of how quality of housing is reflected in social living, the Worcester Recreation Committee (Ref. 13) offers data indicating that the amount of services rendered by volunteer agencies (Boy Scouts, Girl Scouts, Boys' and Girls' Clubs, Youth Center, Y. M. C. A. and Y. W. C. A.) to people from the 25 ward subdivisions was highly correlated (rho = .98, p = <.001—authors' statistics from published raw data, Ref. 13) with ratings of housing in these ward subdivisions. In other words, individuals from the better housing areas (mostly adolescents and young adults) make most use of these sources of recreation and group activity; those from the poorer housing areas make the least use of them.

ward population. Rates per 10,000 of population over 14 years of age were calculated by wards, using data from the 1940 census. An approximation of the population in the one-mile zone was made by adding the populations of all ward subdivisions which are completely in this zone plus an approximation of the percentages of the populations of those ward subdivisions which partially enter the one-mile zone.*

4. *Organization of Data*

The number of patients from each mile zone and the ward rates of admission were obtained for the total study population and according to each category of family setting. Similarly, residential instability or mobility was determined for the total study population and according to each of the categories of family setting.

Results

1. *Distribution, Ward Rates and Residential Instability in the Total Study Population*

Taken *in toto*, the male schizophrenics were distributed throughout the mile zones of Worcester in accord with findings of prior ecological studies. The highest rates occurred in the centrally located ward divisions of the city which have the poorest general living conditions; and the rates for 10 wards are highly significantly correlated ($r = -.85$; $p = <.001$) with the measures of favorability of housing.

Residential mobility played a minor role in determining the residence at admission of the total study population. At one year before admission, 75 per cent of the patients were at their admission residences. Eighteen patients, another 12 per cent, were at different addresses in Worcester, but almost all of them (16 of 18) were in the same neighborhoods or in neighborhoods with the same housing ratings. Five years before admission, 52 per cent, were at their admission addresses; 24 per cent were at different addresses in Worcester, but two-thirds of these (24 of 35) are in the same or in similar neighborhoods. In summation, one year before admission, 86 per cent, and five years before admission, 69 per cent, were at their admission addresses or similar residential areas.

*As Worcester, Mass., is not a census tract city, this basis for delimiting subcommunities and determining hospitalization rates was not used.

2. *Distribution, Ward Rates, and Residential Instability in Relation to Family Setting at Times of First Admission*

Of the patients studied, 79 per cent were living in some family setting at the times of their first admissions. These cases show only a slight (statistically not significant, chi square = 3.24 and p = <.50 >.30) tendency toward concentration in the central mile zone of the city. The correlation between the rates for the persons who were living in a family setting and the housing characteristics of the wards in which they were residing is not statistically significant ($r = -.54$; $p = <.20$).

Only 21 per cent of the patients studied were living in non-family settings at the times of first admissions. These cases show a marked central concentration (statistically highly significant, chi square = 34.2; p = <.001). The correlation for the ward rates of these cases and the ward housing ratings is statistically highly significant ($r = -.80$; $p = <.001$).

Those patients who were living in any family setting at the time of their first admissions showed striking residential *stability;* 95 per cent at a year before admission, and 81 per cent at five years before admission were at the same addresses or in similar residences as at admission. Of these cases, 76 per cent were born in Worcester. In contrast, the patients who were not living in family settings at the times of their first admissions showed striking residential *instability.* Of these persons, 50 per cent were living in Worcester a year before admission and only 29 per cent were residents of Worcester five years before admission. Only 13 per cent of these patients were born in Worcester.

The data and statistics are given in Tables 2, 3 and 4.

Table 2

(a) Distribution of cases by mile zones and family setting

	Family setting				Non-family setting			
	Marital	Parental	Sibling	Total	Single	Divorced	Total	All cases
1st mile zone	23	80	5	108	48	6	54	162
2nd mile zone	21	64	3	88	9	1	10	98
3rd mile zone	4	22	5	31	..	..	..	31
4th mile zone	4	7	..	11	..	1	1	12
5th mile zone	..	2	..	2	..	..	..	2
Totals	52	175	13	240	57	8	65	305

(b) Observed and expected* number of cases in the one mile zone

	Family setting			Non-family setting	
	Marital	Parental	Sibling	Single	Divorced
Observed	23	80	5	48	6
Expected	19.8	66.5	4.94	21.6	3.4
	Chi square = 3.25; p = <.50> .30			Chi square = 34.2; p = <.001	

*Based on the approximation that 38 per cent of the population live in the one-mile zone.

Discussion

The data suggested that both central concentration and the correlation between living conditions and hospitalization rates are largely due to the residential pattern and spatial mobility of a minority of patients—those who are living alone at the time of their first admissions. When these cases are excluded from the total study population, the distribution of cases and rates does not differ significantly from that which would occur by chance or in a random fashion.

Table 3. Housing Characteristics and Ward Rates of First Admission Male Schizophrenics per 10,000 Population Over 14 Years of Age

Ward	Population	Housing favorability rating	Total cases	Total rates	Family cases	Family rates	Non-family cases	Non-family rates
I	15,400	4.3	19	1.23	19	1.23	0	.000
II	18,700	3.4	27	1.44	25	1.34	2	.107
III	25,600	1.2	58	2.27	33	1.29	25	.977
IV	24,400	2.8	39	1.60	38	1.56	1	.041
V	19,800	1.5	29	1.46	25	1.26	4	.202
VI	16,800	3.0	27	1.61	26	1.55	1	.060
VII	15,600	3.5	19	1.22	19	1.22	0	.000
VIII	13,950	1.8	31	2.22	17	1.22	14	1.000
IX	16,500	2.6	37	2.24	26	1.58	11	.667
X	14,400	3.7	19	1.32	15	1.04	4	.278

Pearsonian coefficients of correlation of housing ratings and—

a. total case rates — r = —.85; p = <.001
b. family-setting cases — r = —.54; p = <.20>.10
c. out-of-family-setting cases — r = —.80; p = <.001

Rooming houses or sleeping rooms for men who are living alone tend to be located in the central, poor housing areas of the city. As early studies of urban sociology have pointed out, this is probably a function of the growth and differentiation of the city.[14] Single or divorced men may be said to have "drifted" out of a va-

Table 4. Family Settings at the Times of First Admissions and Residences of Cases, One and Five Years Prior to Hospitalizations; and Residences at Birth

Prior residences	Total		Family		Non-family	
	No.	Per cent	No.	Per cent	No.	Per cent
1 year						
Same	108	74.0	95	83*	13	40.6
Different	18	12.3	15	13	3	9.4
(Different address but in a housing area similar to that of the address at admission)	(16)	(10.4)	(14)	(12)	(2)	(6.4)
Out of city	20	13.7	4	4*	16	50.0
5 years						
Same	75	52.0	73	64.6*	2	6.5
Different	35	24.4	28	24.9	7	22.6
(Different housing area, but similar to admission address)	(24)	(16.7)	(19)	(16.8)	(5)	(15.7)
Out of city	34	23.6	12	10.6*	22	71.0
At birth						
Worcester	83	59.0	78	75.6*	5	13.2
Out of Worcester	58	41.0	25	24.4*	33	86.8

*The evident differences between the family-setting and out-of-family-setting cases are all highly significant $p = <.001$.

riety of living conditions into the central deteriorated areas of the city which offer them housing.

These findings have certain limited psychiatric implications.

(a) There does not seem to be any relationship between the location or the quality of external living conditions of the families of these patients, and the development of schizophrenia. This is consistent with psychiatric experience, particularly in private institutions where wealthy, suburban, well-acculturated, but very sick schizophrenics often are treated. If the sample were enlarged to include patients from private institutions, the writers would predict that the correlation between the rates for the family setting groups and (poorness of) housing conditions would be lower than the statistically non-significant figure obtained here.

(b) It is plausible that, for the persons who are living alone, the necessity of finding housing in the deteriorated, central, highly mobile areas of the city may play some role in enhancing or precipitating overt symptomatology. Psychiatric experience suggests the alternative hypothesis—that these individuals are probably protected from becoming involved in new, disruptive interpersonal relationships by living in these surroundings. One might speculate

that an additional major mode of protection from disturbing close relationships for the single and divorced schizophrenic is the avoidance of meaningful communications or relationships through residential instability.

(c) The findings of this study do not contradict the notion that social structure plays a significant role in the development of personality and psychopathology. Indeed, the writers would suggest that it is most profitable to investigate the subtle, immediate or personalized aspects of social experience and structure. A number of studies have indicated that the immediate, primary group[15, 16] and familial[7, 8] structures are highly relevant to the manifestation of psychopathology.

(d) This study suggests the hypothesis that the family structures which are relevantly associated with schizophrenia are not associated with location in the ecological structure, nor are they correlated with gross measures of the "favorability of living," in the different areas of the city.

Summary

1. The residences of 305 first admissions, male schizophrenics admitted to Worcester (Mass.) State Hospital from Worcester between 1931 and 1950 were located and marked on a street map. Separate mappings were made according to the family setting the patients were living in at this time, e. g., living with parents, siblings, wives, or living alone.

2. There is a "typical ecological distribution" of the total study population. A marked central concentration of cases and rates, and a highly significant (negative) correlation between the rates of first admission male schizophrenics from each ward of the city and measures of "favorability of living" for that ward were noted.

3. The data were analyzed according to the family setting the patient was living in at the time of his first admission. It was then evident that the over-all typical ecological pattern is based on the residential pattern of a minority of patients, the single, separated or divorced men living alone. These patients were markedly concentrated in the central areas of the city, and the rates by wards for them were significantly (negatively) correlated with measures of "favorability of living" in the wards.

4. The majority of patients, however, were living in some family setting at the times of their first admissions, i. e., with their

parents, wives or siblings. These patients were distributed without significant central concentration, and the rates for them by wards were not significantly correlated with measures of the "favorability of living" of the wards.

5. Residence history material indicated that there was greater residential instability for the patients who were living alone at the times of their first admissions than for those who were living in some family setting. The patients who came to the hospital out of a family setting showed striking residential stability, in contrast. This suggests that the over-all central concentration of male schizophrenics is caused by the "drifting" or instability of the single and divorced men, who have moved away from their family settings into the central, deteriorated areas of the city which offer them residential facilities. The interpretation was offered that residential instability may serve as a mode of protection, for these schizophrenic men, against becoming involved in close interpersonal relationships.

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THE IMPORTANCE OF CULTURAL EVALUATION IN PSYCHIATRIC DIAGNOSIS AND TREATMENT

BY STELLA CHESS, M. D., KENNETH B. CLARK, Ph.D., AND ALEXANDER THOMAS, M. D.

The cultural approach to personality has been for the most part concerned with collecting evidence to demonstrate that there is a dynamic interaction between the human organism and its culture and that the personality is patterned in terms of the nature of this interaction and the milieu within which it takes place. Kluckhohn and Murray,[1] in discussing group membership determinants of personality, state this point of view clearly:

"The members of any organized enduring group tend to manifest certain personality traits more frequently than do members of other groups. . . . In distinguishing group-membership determinants, one must usually take account of a concentric order of social groups to which the individual belongs, ranging from large national or international groups down to small local units. . . . Not only the action patterns, but also the motivational systems of individuals are influenced by culture."

This orientation to the problems of personality evaluation does not seem to have influenced thinking and practices in the field of clinical diagnosis and treatment of disturbed personalities to the same degree and rate with which it has permeated the more academic theoretical approaches to personality. Very little direct evidence in support of the cultural approach to personality has come from the vast literature of clinical psychiatry. Among the reasons for this may be the strong influence of the Freudian instinctual theory of human personality. In addition, the criteria for psychiatric diagnosis and classification are too often taught to the student in an abstract, generalized fashion, without the concept that to ignore the cultural milieu of the patient may lead to incorrect evaluation of these criteria and incorrect diagnosis.

This paper will attempt to demonstrate that these diagnostic categories cannot be rigidly applied without taking into account the social situation within which the patient developed and seeks to function. It is the intention of this paper to illustrate the fact that the usual psychiatric criteria for evaluating personality are of dubious value if they are not used with the understanding that the same overt behavior patterns may mean very different things in different people and reflect different psychodynamics in indi-

viduals functioning in different situations, and in individuals from different cultural backgrounds. The experience gained at the Northside Center for Child Development, a child guidance center which serves children in the Harlem community of New York City, is used as a basis of discussion.

The children seen in this center come from different cultural, racial, religious, economic and social backgrounds. Not only are the children and their families of different racial, national and religious backgrounds, but the professional staff is also interracial and intercultural. The experience at the Northside Center during the past five years has provided rich case data which seem pertinent to the problem of the effects of cultural factors on psychiatric diagnosis and treatment. These data show that it is necessary to understand the cultural background and context within which the individual has developed and is seeking to function, not only to make a more precise diagnosis of his problems, but also to evaluate effectively the processes, stages and rate of progress in therapy. It is believed that this insight can lead to more effective clinical procedures in psychiatry, as well as to presenting evidence in support of an objective and realistic theory of the relation between culture and personality.

In the pursuit of evidence related to the problems of culture and personality, one must be careful not to fall into some rather obvious and some more insidious pitfalls in interpretation. One of the most glaring pitfalls found in some of the literature is the tendency to make sweeping generalizations concerning culturally-determined differences in behavior patterns which are not backed up by evidence, but are arrived at by apparently rigid preconceptions of the author. These are not unlike the layman's stereotypes extended into allegedly scientific articles. An example of this type of thinking is found in an article by Hunt[2] in which he attempted to show that: ". . . the psychoneuroses, while occurring among Negroes, were relatively less frequent in the Negro group than in the white group. The psychological conflicts of the Negro group seemed of a more simple, elementary nature resulting in the less complex type of symptomatology typical of sociopathic behavior, emotional instability, inadequate personality, simple maladjustment, and temperamental unsuitability. The tortuous, intricately structured mechanisms typical of psychoneurosis seemed to be less common."

The possibility that this difference might not be a real or significant one, but rather a reflection of a lack of rapport between a white diagnosing officer (the patients were white and Negro sailors at a psychiatric unit of a large naval installation during the last war) and Negro patients; or that it might reflect lack of ability on the part of the diagnosing person to bridge the cultural gap between Negroes and whites and understand that there may be some variations in symptom-expressions of neuroses in Negroes is not considered and discussed by Hunt. Instead he attempts to justify his position without appropriate evidence that psychoneuroses are correlated with high education, high intelligence and social superiority; and that psychiatric disturbances among Negroes —and emphasizing his stereotyped thinking in reference to Negroes in general, he adds, "culturally handicapped whites as well" —are not frequently diagnosable as neurotic and "do not resemble the classical picture of hysteria, but rather the behavior of an extremely suggestible, uncritical, emotionally unstable individual." He does not describe the picture of "classical hysteria" or does he tell under what conditions these "classical" cases may be observed outside of textbooks, but he concludes: "Under these circumstances, a diagnosis of emotional instability, seems more fitting than one of true hysteria or conversion neurosis." Needless to say, such studies contribute little to our understanding of the complex problems involved in an understanding of the relations between cultural factors and personality organization and disorganization.

In contrast to this, Ripley and Wolf[3] state that the incidence of psychoneuroses and psychoses was found to be appreciably higher among Negro than white troops. These authors also indulge in rash generalizations concerning the racial differences between Negro and white troops in "certain observable emotional and intellectual characteristics." Among the authorities they cite in support of their observations, are some individuals who published speculative articles on this problem in 1914.

Stevens,[4] on the other hand, calls attention to some of the real problems involved in the psychiatric approach to the emotional problems of Negro soldiers. He believes that the crucial racial factor to be taken into account in the understanding of the psychiatric problems of the Negro soldier was the existence of racial segregation in the armed services. He states:

"Although the effect of segregation on the Negro inductee was not dramatic and immediate, it was continuous. It produced an emotional cancer, whose growth depended to a great extent on the other important racial factor, discrimination." These factors influenced not only the soldier's morale and general adjustment to the army, but also his relations with army psychiatrists. According to Stevens, army psychiatrists differed markedly in their understanding of the emotional problems of Negroes when those problems were related to social factors. Stevens says: "One psychiatrist, after offering a rather dogmatic opinion concerning the Negro to a small group discussing this subject, admitted that his knowledge was the result of eight years of contact with his office maid, who was a disciple of Father Divine. Another, after drawing a broad conclusion concerning Negro soldiers, admitted that his conclusion was based to a great extent on contact with six Negro members of a religious cult. . . . Certainly many fail to understand that a history of intermittent school attendance and frequent changes of jobs is not in some communities indicative of emotional instability, but the result of an effort to survive."

Verin,[5] and Houwink[6] point in realistic terms to the significance of the color and culture factor in a social case work relationship between Negro patients and white workers.

Davis,[7] Davis and Havighurst,[8] and Brenman[9] have demonstrated that there are significant differences in patterns of personality adjustment according to social class among Negroes. That variation in adjustment in terms of class position is not peculiar to Negroes, but is found also among whites, is established by a substantial bulk of objective sociological research.

The more subtle error of underdiagnosis or minimizing the personality problems of individuals of a different culture might also be avoided with a more realistic and objective understanding of the effects of cultural factors on personality adjustment. It is likely that a psychiatrist who was insensitive to those factors and who had accepted the existing racial stereotypes would assume when confronted with really disturbed Negroes who manifested psychotic patterns that these were merely manifestations of the normal "racial characteristics" of these people.

Ripley and Wolf[3] state: "It is a common but probably mistaken idea that it is usual for normal Negroes to hear voices or see visions." In spite of their recognition of the probability of this

being a mistaken idea, they continue a discussion of this problem, quoting from O'Malley who published an article in 1914 ("Psychoses in the Colored Race" in the *American Journal of Insanity,* 71, 309-337): "However, certain psychological differences between the Negro and white man that bear on this question, have been described. O'Malley found that Negroes are superstitious, changeable in impulse and emotional, lacking in grasp of abstract ideas and tend to transform the visionary into reality in such a way that the transition between real, supernatural, and hallucinatory experiences is difficult to establish in many cases. Lewis and Hubbard (*Manic-Depressive Psychoses,* Williams & Wilkins, Baltimore, 1931, Chap. 38, pp. 779-816) found that the American Negro, in contrast to more highly civilized races, shows a comparative lack of self-consciousness, draws a fainter line of demarcation between will and destiny, illusion and knowledge, and dreams and facts, and makes less distinction between hallucinations and objective existence."

This is clearly the ordinary variety of racial prejudices and stereotypes disguised as scientific psychiatric interpretation.

This type of pseudo-scientific distortion in the thinking of psychiatrists may do irreparable harm if the individuals having these prejudices are charged with the responsibility of providing therapy for minority group members assigned to them.

It is, therefore, most important to attempt to demonstrate the objective relationship between culture and personality.

Illustrative Cases

The following cases from the records of the Northside Center are presented as typical examples of the fundamental ways in which differences in cultural backgrounds influence the weight and evaluation given specific personality patterns in psychiatric diagnosis and therapy.

Case 1. Jane was an attractive seven and one-half-year-old Negro girl who was brought to the Northside Center because of nervousness, forgetfulness, and confusion about family relationships. She tended to be domineering with playmates, but with adults was talkative and friendly in an indiscriminate fashion. She came from a broken home, and had lived in two different foster homes. The first foster parents complained that she was aggressive and unmanageable. The confusion about family relationships

was very understandable. Not only had she lived in three different homes, but she and her sister, who lived a block away, used the different surnames of their respective foster parents. Also Jane's foster parents from time to time cared for other temporary foster children, and during their residence in the household these children were called sisters and brothers.

In play therapy she showed compulsively neat activity with each toy, but disorganized, disconnected and confused play with an inability to sustain any one theme, and easy distractability by outside stimuli. Her verbalizations were facile and the psychiatrist felt that Jane made only a superficial relationship to her.

The differential diagnosis was between neurotic personality with confusion as to identity, and psychopathic personality. After two months of weekly play therapy sessions, she began to show silly, buffoonish and "sassy" behavior, alternating with ingratiation. The therapist's questions were either ignored, mimicked or ridiculed. This behavior continued for the next three months, and the therapist finally considered her inaccessible to therapy, with the diagnosis of psychopathic personality. The therapist recommended that therapy be discontinued. However, at this time, a report of the child's outside living-relationship gave an entirely different perspective on the results of treatment. The report indicated that the child had improved dramatically and markedly in every area of functioning. It was clear that the therapist's evaluation had been completely incorrect; and discussion of the case revealed that the therapist, a white woman, was judging the child's reactions to her, without giving adequate consideration to the fact that the child was Negro and that this would profoundly influence her reactions to any white person. In terms of the hostile, unbridgeable gap that this Negro child felt between her and any white woman, the development of this buffoonish behavior actually represented a movement toward the therapist. Her "carrying on" in this flippant manner was her manner of establishing a relationship with this hitherto awesome, threatening figure, rather than an inability to establish a relationship.

Case 2. Edward was an eight-year-old Negro boy, referred to the center with a variety of symptoms and fears in his school situation. He wet himself in school, didn't play with the other children, would not read, and was afraid of the teacher. At home, he manifested none of this behavior.

His symptoms were intense, and ordinarily would have been considered evidence of serious emotional disturbance. However, evaluation in terms of social setting shed different light on them. His family had recently come from the South, where they had been sharecroppers and had lived on a marginal income. They had had a number of fear-inspiring experiences with white people, in which they were cheated, threatened, intimidated and terrorized. Edward, like the rest of the family, had been taught not to fight back with white people, and to exercise the greatest care not even to express his thoughts and feelings to them. In New York he found himself in a strange, bewildering school set-up, and had a white teacher for the first time. In terms of his experiences and conditioning with white authority figures, it was normal for him to be fearful, afraid to ask questions, and even afraid to ask permission to go to the toilet. It is not strange that he could neither learn nor hold his own with the other children in such a setting.

The final diagnosis was a situational reaction in an essentially normal boy. This diagnosis was confirmed by the rapid strides he made in treatment, which included active work with the school.

Case 3. Arnold was a 12-year-old Negro boy, referred to the center because of delinquent behavior, which included stealing a car in company with his 15-year-old brother and another boy to go joy riding. His previous history included entering a friend's home and taking a loaded pistol, which was then discharged, wounding him in the left wrist. Had he been a middle class white boy the diagnosis of psychopathic personality undoubtedly would have been made. There was a history of repeated delinquent behavior plus several accidents while hitching rides. He showed no anxiety or defensiveness when questioned about his delinquencies. When asked what was wrong in what he did, his answer was that they should have abandoned the car in Central Park, then they wouldn't have been caught. His first contact with the therapist was superficial, and his attendance record at therapeutic sessions was poor. However, in view of his social environment, in which group activity and identification centered around gangs, the psychopathic personality diagnosis was rejected. He had exhibited a sense of responsibility, according to his standards, by trying to dissuade his brother from stealing the car with the others because his brother was already on parole. He was loyal to his gang—his subgroup. Also, in the therapeutic sessions he did at-

tend, he did show good object relationships and worked effectively.

The writers' initial experience at Northside Center with the necessity of evaluating diagnosis in terms of the concept that personality development is an integral part of the social and cultural background was seen in the case of Jane. The case illustration here is so very vivid because the criteria applied did not take these social factors into consideration; and diagnosis, method of treatment and prognosis were all inaccurately judged. The validity of the re-evaluation was proved by the fact that it correctly prognosticated the excellent progress which took place.

The two other cases illustrate the use of the knowledge acquired in scrutiny of the center's methods, stimulated by Jane's case. It has become the custom never to make a diagnosis unless some member of the staff is present who is familiar with the particular cultural background. If this cannot be achieved, the center has sought other people in the field who are familiar with the particular cultural background, and asked their participation. From this experience, Arnold for example, could not be seen as a psychopathic child in view of his high degree of conformity with the ethics, activities and mutual responsibilities of his particular group.

Edward also could not possibly have been accurately evaluated if his behavior in school had been judged on a level with that of a child whose background had not included this boy's living experiences. A white northern, urban middle class boy showing Edward's degree of fear of the teacher, to the extent of becoming intellectually paralyzed and inarticulate, would have had to be a very sick boy having exceedingly destructive total relationships. A Negro boy brought up in Georgia, whose own family and close relatives had suffered humiliation, deprivation, and cheating from white employers, with no possibilities of successful defense, is certainly expressing bewilderment by his behavior. However, considering the fact that he is transferred to a white teacher, the first in his experience, panic, defensive guardedness and retreat into non-activity, do not have the same serious pathological implications as for a child from a different environment, and the symptoms are more amenable to successful alteration.

Thus, the writers have come to feel that unless the social milieu in which the patient functions is understood and given adequate consideration, significant errors in psychiatric diagnosis, progno-

sis and evaluation of treatment will occur. This conclusion grew inevitably out of work with patients whose social environments differed sharply from those of the white middle class groups who have provided the dominant source for psychiatric studies. The same type of errors should therefore, tend to occur in psychiatric work with other groups in which there is marked difference in cultural setting from this dominant source.

Davis[10] in a speech before the Mid-Century White House Conference on Children and Youth in Washington, in December 1950, stated: "The vast store of ability in millions of children in the lower socio-economic groups is largely wasted because their teachers do not understand the basic cultural habits of the working groups."

Professor Davis pointed out that the majority of our children in the public schools come from the lower socio-economic groups, while 95 per cent of the teachers are from the middle socio-economic groups and that this results in a great cultural gap. Among the results of this cultural discrepancy is the tendency of "middle class teachers, clinicians and psychiatrists" to label as "delinquent behavior," patterns in these children which are to them realistic, adaptative and socially acceptable responses to their cultural reality. He stated: "In lower class families, physical aggression is as much a normal, socially approved, and socially inculcated type of behavior as it is in frontier communities."

Another special situation occurred in the armed forces during World War II. Here, millions of civilian young men found themselves suddenly transplanted into an environment basically different, especially under combat conditions, from that in which they had developed and lived. It is not surprising, therefore, that many of the psychiatric reports from the wartime army questioned the adequacy and even the validity of the standard psychiatric criteria. Thus, Plesset[11] reported on the infantry division which, when it went overseas, included 138 soldiers with diagnoses of psychoneurosis or constitutional psychopathic state. None had received any intensive therapy, most had had only one brief diagnostic interview, and 25 were considered especially poor risks. Plesset anticipated seeing most of the group of 138 as patients in the first few days of combat, if not earlier. However, after 30 days of combat under winter conditions, fighting and living in snow and mud, only one was evacuated for "exhaustion." After

60 days of combat, three others were evacuated, leaving 134 still active on combat duty, and, in the subsequent three months, there were no further psychiatric casualties from this group. Raines,[12] reporting on psychiatric experience in the navy early in the war, declares, "When we were thrown into this cold, shortly after the onset of the war, and attempted to approach the problem with the standard and accepted psychiatric theories, we found ourselves in a predicament. We found specifically that the better trained the psychiatrist was, the fewer combat fatigue patients he seemed to get well. That was rather startling."

Wright,[13] found that the study of the psychological reactions of aerial crews in combat "has shown most strikingly that psychodynamic phenomena cannot be thought of in a valid or productive way outside of their situational contexts." He also reported the experience of seeing many men who were considered neurotic and inadequate function effectively in combat, and, on the other hand, seeing many previously unusually well-integrated personalities break down with severe neurotic disturbances. In the Tunisian campaign, Spiegel[14] found that, "A state of tension and anxiety is so prevalent in the front lines that it must be regarded as a normal reaction in this grossly abnormal situation. . . . A tense, tremulous soldier was not necessarily a psychiatric casualty. He was if we made him one and sent him back, but often he was not a casualty, simply because he was not permitted to be one." Finally, Maskin[15] reported how in a combat division the diagnosis of psychoneurosis and combat exhaustion was determined by all sorts of environmental factors.

Thus, it is indicated that it was not possible to apply without qualification the standard psychiatric criteria for diagnosis, treatment and prognosis to psychiatric problems in the wartime army. On the basis of experience at Northside Center, it is suggested that this confusion occurred because the environmental conditions in combat were so radically altered from those in which the psychiatric criteria had been developed that these criteria were no longer accurate.

Finally, it can be noted that in the field of psychological testing, leading workers are now emphasizing the decisive influence of cultural and environmental factors in determining test results. As summarized by Klineberg,[16] "The history of the mental testing of

ethnic or racial groups may almost be described as a progressive disillusionment with tests as measures of native ability, and a gradually increasing realization of the many complex environmental factors which enter into the results." This same point is made even more sharply by Goodenough and Harris:[17] "The search for a culture-free test, whether of intelligence, artistic ability, personal-social characteristics, or any other measurable trait is illusory, and . . . the naïve assumption that the mere freedom from verbal requirements renders a test equally suitable for all groups is no longer tenable."

To generalize, the concept that personality emerges only in terms of its social setting means that an evaluation of the healthy or morbid psychological aspects of an individual can be made only in terms of what is appropriate and effective functioning within the specific cultural milieu. If this principle is not kept in mind, then the frequent difference between patient and psychiatrists in social, economic, or cultural status will lead the psychiatrist to make the error of using his own status as the norm and that of the patient, if different, as the deviation from the norm. Where the patient has undergone a change in cultural environment, a lag in adaptation to the new circumstances, while possibly annoying and incomprehensible to various figures in the new environment, cannot be justifiably equated with morbidity of personality structure. On the other hand, severe deviations cannot be lumped under the heading of lag in adaptation. The judgment can be made accurately only by an examiner who is already familiar with, or makes himself cognizant of, those cultural factors which were an integral part of the development of personality, and who also is familiar with the personality types developing as the norms of the patient's cultural group.

As can be seen, the discussion has moved from a consideration of diagnostic criteria to an examination of personality development. The experiences reported and the views cited are incompatible with the approach to personality in terms of a basic fixed human nature or of a racist approach to variation in human behavior. It is the purpose of this paper to indicate the errors in diagnosis and management in treatment that can result from such an approach, and to suggest the necessity of evaluation in cultural terms if these errors are to be avoided.

SUMMARY

Experience at a child guidance center with patients drawn from varying national and racial backgrounds shows the necessity for evaluating cultural factors for accurate diagnosis and optimum treatment. A number of case histories are reported in which there were significant cultural differences between the patient and the examiner or therapist, and where appreciable errors of diagnosis and evaluation of treatment occurred, or were under consideration, because the examiner or therapist was not sufficiently aware of these cultural differences and their manifestations.

A number of psychiatric reports are also cited from World War II which noted difficulties when standard psychiatric criteria from civilian life were applied without taking into account the radically different cultural setting in the war-time army. A similar development is reported in the field of psychological testing, where leading workers have become increasingly aware of the decisive importance played by cultural factors in determining test results. The theoretical implications of these findings regarding the significance of the cultural factors in psychiatric evaluation are discussed.

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THE CONCEPT OF THE UNCONSCIOUS IN THE HISTORY OF MEDICAL PSYCHOLOGY*

BY EDWARD L. MARGETTS, M. D.

A. Introduction

Most psychiatrists nowadays, whether they utilize the concept of the unconscious in psychotherapy or not, have some working idea, however vague, of an unconscious mind, which they find useful in their theoretical frames of reference. There is a vast amount of historical fact which indicates that almost since the dawn of civilization man has had an inkling of understanding that mind activity outside of our waking consciousness does truly exist. It is not the intention here to go exhaustively into the details of such beliefs, but to mention a few specific examples in order to show that for thousands of years man has had this inkling, which, one grants, many times seems vague and incomplete. There are a great many written words describing such things as body-mind-soul, perception, stimulus-response, memory, instinct, association, dreams, and other unusual states such as trance, double personality, automatic behavior, unreality feelings, in ways that allow us to ponder the question that the understanding of unconscious processes was established long before the advent of our "modern" theories on this fascinating subject.

The word "unconscious" has a considerable number of meanings, even in current thought. The author does not intend to get himself lost in a quagmire of definitions and controversies. Every psychiatrist has as many ideas as he in this regard.[1] Most of the arguments propounded against the idea of an unconscious consist of rather feeble bone-picking philological negativisms such as "There are no such things as unconscious ideas—or unfelt feelings." The aim of this paper is to wander hither and yon through history, and to sift out some facts which contribute to the thesis that the unconscious is an old and oft-revised concept.

B. The Ancient World

Out of ancient India came the first clear formulation of the idea of a stratified consciousness.[2a, 3, 4, 5, 6a] Probably the earliest work to indicate this is the *Upanishads*, a collection of documents of

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about 600 B. C., which constituted a written presentation of the efforts of the Hindus to construe the world as a rational whole, and to regard the ultimate as a unification of the individual self with the Supreme Being, the Absolute, Brahma. Sanskrit scholars have written in great detail about the "type of soul," or levels of consciousness, in the Upanishads,[3, 4, 5, 7] which strongly influenced such modern philosophers as Arthur Schopenhauer and Paul Carus[2a] who both had clear theories of unconscious mind. The Upanishads, particularly *Mandukya Upanishad* 3-11 (Ref. 5, pp. 391-3),* set forth quite clearly the "four states of self." They are:

1. The waking state (*jagarita-sthana*): equivalent to the "conscious." In this state, man accepts the universe as he finds it. Perception, volition, and memory are preserved. This level is recognizable in the well-developed animal kingdom, including man. (According to *Vedanta* philosophy, a psyche exists in the animal, vegetable and mineral kingdoms.)

2. The dreaming state (*svapna-sthana*): the "subconscious." Here the self loses contact with reality, and the soul fashions its own world in the imagery of its dreams. The Brahmins had a very interesting conception of dreams (see *Prasna Upanishad* 4-5—Ref. 5, p. 386). The usual state of mind in the less developed animal kingdom.

3. The deep-sleep state (*susupta sthana*): a deeper level of the subconscious approaching complete unconsciousness. This is a state of bliss in which there is no contact with reality, no desire, no dreams. This is the normal situation in the vegetable and mineral kingdoms.

4. The fourth state (*caturtha, turiya, turya*): the "super- (or supra-) conscious." "According to *Vedanta*, it is in this state that Seers get flashes of Great Truths in the form of vague apprehensions, which are afterwards elaborated in the *jagrat* state or waking consciousness."[5] Deussen[3] reasoned that full appreciation of this state of soul became prominent with the rise of the Yoga school, which believes that by intense meditation and self-control, the union of the human soul with the Supreme Soul, Brahma, may be achieved, *with the maintenance of the waking consciousness.*

One wonders if ancient Egypt had much of interest to offer us, but so far as this writer is able to discover, there is little in Egyptian philosophy that bears on the subject. There were at least six

*Accents have been omitted from Sanskrit words.

different kinds of soul which were accepted by the early inhabitants of the Nile valley, but they corresponded more to modern concepts of ego, super-ego and id than to our ideas about an unconscious. The same might be said about the three souls of Plato (427-347 B. C.) (Ref. 9: *Timaeus the Locrian*: Burges. Bohn Vol. VI, p. 160. *Timaeus* XIX, XLIV: Davis. Bohn Vol. II, pp. 349 and 380) which are treated in a similar way in the New Testament—spirit, psyche, flesh, equivalent to super-ego, ego, and id,[2b] and in the Egyptian Hermetica[10] and the sense of which was first clearly set forth in the *Katha Upanishad* (3. 10 and 11—Ref. 5, p. 352):

"10. Higher than the senses are the objects of sense.
Higher than the objects of sense is the mind (*manas*);
And higher than the mind is the intellect (*buddhi*)
Higher than the intellect is the Great Self (*Atman*).

"11. Higher than the Great is the Unmanifest (*Avyakta*).
Higher than the Unmanifest is the Person.
Higher than the Person there is nothing at all.
That is the goal. That is the highest course."

The idea here is that the individual soul becomes one (unified) with Brahma. (See *Brihad-Aranyaka Upanishad* 4. 4; 2.—Ref. 5, p. 139.)

Plato also set forth his waxen tablet explanation of memory, which is well known and contributes something to the matter of present interest. (Ref. 9, *Theaetetus* 118: Cary. Bohn Vol. I, p. 431.) In discussing dreams, Plato seemed to approach closer to a belief in an unconscious than he did in writing of the three souls, although in the latter he had a clear idea of what is now meant by "repression" (Ref. 9, *Timaeus* XLIV: Davis. Bohn Vol. II, p. 380). The *Republic* (XI, 1: Davis. Bohn Vol. II, p. 260) reads as follows: "Of pleasures and desires that are not necessary, some seem to me contrary to law,—which indeed seem engendered in all men:—though owing to the correction of the laws, and of improved desires aided by reason, they either forsake some men altogether, or are less numerous and feeble, while in others they are more powerful and more numerous. Will you inform me what these are? said he. Such, said I, as are excited in sleep, when the rest of the soul—which is rational, mild, and its governing principle, is asleep, and when that part which is savage and rude, being sated with food and drink, frisks about, drives away sleep, and

seeks to go and accomplish its practices;—in such an one, you know, it dares to do everything, because it is loosed and disengaged from all modesty and prudence: for, if it pleases, it scruples not at the embraces, even of a mother, or any one else, whether gods, men, or beasts; nor to commit murder, nor abstain from any sort of meat,—and in one word, it is wanting neither in folly nor shamelessness."

To discuss the vast literature on dreams would lead far afield from the subject, and reference to the recent anthology of Woods[11] will give the interested reader a selection of examples derived from ancient and modern writers. Dreams and their meanings have had a great deal to do with the various formulations of mind activity outside of waking consciousness. From primitive times to the present, dream interpretation has been a part of "psychotherapy." The best example, of course, is the incubation sleep of the temples in Egypt, Greece and Rome.

Aristotle (384-322 B. C.) came much closer to a clear appreciation of mental activity outside of consciousness than did Plato, his teacher. In the *De Memoria et Reminiscentia,*[12] Aristotle set forth his theories of memory, association, and mental activity of which the subject was unaware. Extracts from this work are so clear as to require but little explanation: "(450a-30). The process of movement [sensory stimulation] involved in the act of perception stamps in, as it were, a sort of impression of the percept, just as persons do who make an impression with a seal. [This simile comes from Plato, *Theaetetus, supra.*]* . . . (451a-5). We can now understand why it is that sometimes, when we have such processes, based on some former act of perception, occurring in the soul, we do not know whether this really implies our having had perceptions corresponding to them, and we doubt whether the case is or is not one of memory. But occasionally it happens that [while thus doubting] we get a *sudden idea*** and recollect that we heard or saw something formerly. This [occurrence of the 'sudden idea'] happens whenever, from contemplating a mental object as absolute, one changes his point of view, and regards it as relative to something else. . . . (452a-5). It often happens that, though a person cannot recollect at the moment, yet by *seeking*** he can do so, and discovers what he seeks. This he succeeds in doing by set-

*Present writer's comment.

**Italics the present writer's.

ting up many movements [sensory stimulations]* until finally he excites one of a kind which will have for its sequel the fact that he wishes to recollect. . . . (452a-15). But one must get hold of a starting-point. This explains why it is that persons are supposed to recollect sometimes by starting from mnemonic *loci*. The cause is that *they pass swiftly in thought from one point to another,*** e. g., from milk to white, from white to mist, and thence to moist, from which one remembers Autumn [the 'season of mists'], if this be the season he is trying to recollect.

"It seems true in general that the middle point also among all things is a good *mnemonic starting-point*** from which to reach any of them. For if one does not recollect before, he will do so when he comes to this, or, if not, nothing can help him. . . . (451b-25). Thus, then, it is that persons seek to recollect, and thus, too, it is that they recollect even *without the effort of seeking to do so,*** viz., when the movement implied in recollection has supervened on some other which is its condition [i. e.—non-voluntary, without effort of will]* . . . (452a-1). Accordingly, things arranged in a fixed order, like the successive demonstrations in geometry, are easy to remember [or recollect], while badly arranged subjects are remembered with difficulty. . . . (453a-10). The cause of this is that recollection is, as it were, a mode of inference. For he who endeavors to recollect infers that he formerly saw, or heard, or had some such experience, and the process [by which he succeeds in recollecting] is, as it were, a sort of investigation."

C. The Gloom of the Dark Ages

From the age of Greek philosophy to the Renaissance, little more was brought forth except in India, where the religious philosophers developed the ancient ideas of levels of consciousness and applied them particularly to states of meditation, trances, and so on. Farther west, the ideas of the Greeks were carried on through the Dark Ages.

Saint Augustine (354-430 A. D.), in the *Confessions*,[13] wrote, with fine understanding, at considerable length about memory. He described memories which could be recalled instantly, and those which took time to come to mind, being "hidden from sight," or more deeply rooted in the mind: "others must be longer sought after, which are fetched, as it were, out of some *inner receptacle*"**

*Present writer's comment

**Italics the present writer's.

[X:VIII (12), Ref. 13, p. 211], c. f. *unconscious*. Elsewhere he wrote: "even when the mind doth not feel, the memory retaineth" [X:XVII (26), Ref. 13, p. 219]. Finally, he dealt with falling out of memory, seeking the recognition by part association, and complete forgetfulness. This showed an appreciation of memory levels which has never been much improved upon. The passage runs: "But what when the memory itself loses anything, as falls out when we forget and *seek** that we may recollect? Where in the end do we search, but in the memory itself? and there, *if one thing be perchance offered instead of another, we reject it,** until what we seek meets us; and when it doth, we say, 'This is it'; which we should not unless we recognized it, nor recognize it unless we remembered it. Certainly then we had forgotten it. Or, had not the whole escaped up, but by the *part** whereof we had hold, was the lost part sought for; in that the memory felt that it did not carry on together all which it was wont, and maimed, as it were, by the curtailment of its ancient habit, demanded the restoration of what it missed? For instance, if we see or think of some one known to us, and having forgotten his name, try to recover it; whatever else occurs, connects itself not therewith; because it was not wont to be thought upon together with him, and therefore is rejected, until that present itself, whereon the knowledge reposes equably as its wonted object. And whence does that present itself, but out of the memory itself? for even when we recognize it, on being reminded by another, it is thence it comes. For we do not believe it as something new, but, upon recollection, allow what was named to be right. But were it *utterly blotted** out of the mind, we should not remember it, even when reminded. *For we have not as yet utterly forgotten that, which we remember ourselves to have forgotten.** What then we have utterly forgotten, though lost, we cannot even seek after" [X:XIX (28), Ref. 13, p. 221].

The great Arab physician Rhazes (864-925 A. D.) was an astute psychologist, and drew from Plato when writing of the soul and emotions. In his *Spiritual Physick*,[14] Rhazes applied the Platonic idea of suppression of the passions in order to maintain the health of the body. In the twelfth century, Isaac, the English-born abbot of Stella in Poitiers, apparently had an appreciation of unconscious mental activity. In writing of the soul, he pointed out "not

*Italics the present writer's.

everything known is continually present, nor does all that a man knows remain at all times directly to the eye of the mind [*nec versatur semper in intuitu scientis omne quod scitur*]."[15]

D. The Light of the New Learning

During the stagnation and retrogression of the Dark Ages, there are to be found no additional illustrations of the subject with which this paper is concerned. Toward the end of the fifteenth century, born within a year of each other, two great names in medicine come to attention, and apparently both of them had an understanding of mental processes outside of awareness. They were Paracelsus (1493-1541) and Juan Luis Vives (1492-1540). Paracelsus believed that mental illness was due to unhealthy changes in the *spiritus vitae*, and rejected the prevalent demonological concept of mental illness, which in itself was no mean accomplishment for his time, since everybody believed that people became mentally ill from inhabitation of the body by demons or spirits. He offered the name "*chorea lasciva*" for St. Vitus' dance, and suggested the sexual nature of hysteria. He formulated the theory that imaginative ideas, elaborated from seeing or hearing something, were the cause of hysteria: "their sight and hearing are so strong that unconsciously they have fantasies about what they have seen or heard." According to Zilboorg (Ref. 16, p. 199) this deep insight of Paracelsus was (probably) "the first reference to the unconscious motivation of neuroses in the history of medical psychology." The Spaniard, Vives, devoted his life to education and social reform, particularly to relief for the poor and mentally ill. He clearly saw the importance of psychological associations and *recognized the emotional content that many associations carried with them.* He described in *De Anima et Vita* (1538) how ideas could be registered without our conscious knowledge and could later be discovered by association.[16, 17] There seems to be little doubt that these theories were directly elaborated from Aristotle.

E. Philosophy, Psychology and Medicine

The seventeenth century saw the resurrection of the age-old problem of mind-body relationships. Over the next two centuries, much was to be written on this subject, and the problem gradually evolved from its situation as one of the most prominent in philosophy to one of the most intriguing in scientific psychology and in

medicine. From the psychiatric point of view, it would appear that since 1700 there have been two important peaks in the history of mind-body theories. The first was apparent as the war between psyche and soma which raged in Germany from 1800 to 1850 and which culminated in the victory of the somatic school under Jacobi and his followers.[6b] The second is still going on in the conflict between the adherents to the theories of psychic and those of organic causation. Why there should be such extremist viewpoints at the present day is *difficult* to understand, but *understandable!* One may suppose that only by thoroughly investigating each of them can we completely understand how the extremes may be unified into a meaningful whole, a psychobiological theory which includes every facet of man and his environment.

The writings of René Decartes (1596-1650) and John Locke (1632-1704) did much to delineate the meaning of *consciousness,* which was equated with *mind.* Following their work, the problems of psychology became largely those of consciousness. A number of thinkers who took exception to this notion were those who included in their psychology mind activity outside of consciousness. They are the ones to be discussed now.

F. Philosophy

One of the first philosophers to devote very much thought to the idea of an unconscious was the German, Gottfried Wilhelm Leibniz (1646-1716),[18] whose philosophical framework supported the thesis that ideas existed in a latent or potential (i. e., unconscious) form. For Leibniz, the world was a system of souls, or monads, which were miniature forms of the whole system. There were no connections between one monad and another; they seemed to interact only because of "pre-established harmony" between them. The inner development of each monad was so prearranged in the creation of the world that all its changes were accompanied by corresponding changes in other monads.

There was no clear-cut division between consciousness and unconsciousness. The principle of continuity was followed; the one shaded into the other—unconscious perception, (*petites perceptions*, vague and obscure ideas, subconscious activities) gradually merged with conscious apperception. We read the following in *New Essays on the Human Understanding* (1704): "Besides these are countless indications which lead us to think that there is at

every moment an infinity of *perceptions* within us, but without apperception and without reflexion; that is to say, changes in the soul itself of which we are not conscious [s'apercevoir], because the impressions are either too small and too numerous or too closely combined, [trop unies], so that each is not distinctive enough by itself, but nevertheless in combination with others each has its effect and makes itself felt, at least confusedly, in the whole (Ref. 18, p. 370). . . . These unconscious [*insensible*] perceptions also indicate and constitute the identity of the individual, who is characterized by the traces or expressions of his previous states which these unconscious perceptions preserve, as they connect his previous states with his present state; and these unconscious perceptions may be known by a higher mind [*esprit*], although the individual himself may not be conscious of them, that is to say, though he may no longer have a definite recollection of them . . ." (Ref. 18, p. 373).

In *Principles of Nature and of Grace, Founded on Reason* (1714), Leibniz again clearly stated this idea: "Thus it is well to make distinction between *perception*, which is the inner state of the Monad representing outer things, and *apperception*, which is *consciousness* or the reflective knowledge of this inner state, and which is not given to all souls nor to the same soul at all times." (Ref. 18, p. 411.) In the *Monadology* (1714) we read: "And as, on waking from stupor, *we are conscious* of our perceptions, we must have had perceptions immediately before we awoke, although we were not at all conscious of them; for one perception can in a natural way come only from another perception, as a motion can in a natural way come only from a motion" (Ref. 18, p. 231).

An older contemporary of Leibniz was Benedict Baruch Spinoza (1632-1677). His most interesting work from the point of view of modern psychiatry was the *Ethica Ordine Geometrico Demonstrata*, first published in 1677.[19] This book, which included material relating to mind-body (monism), association, memory, dreaming, and the various emotions, appeared more than a quarter of a century before Leibniz wrote the essays which have already been discussed. One gathers from Spinoza that he had a conception of subconscious phenomena and their interplay with emotions. Quotations may be cited relating to sleep, association, and emotion which seem to tie together pretty well: "For when the body is asleep, the mind, at the same time, *remains unconscious*,* and has not the power of

*Italics the present writer's.

thinking that it has when awake (*Ethics* III, Prop. II, Note. Boyle, p. 87). . . . And hence we can clearly understand why the mind from the thought of one thing should immediately fall upon the thought of another which has no likeness to the first (*Ethics* II, Prop. XVIII, Note. Boyle, p. 56) . . . An emotion which is a passion ceases to be a passion as soon as we form a clear and distinct idea of it . . . Therefore the more an emotion becomes known to us, the more it is within our power and the less the mind is passive to it." (*Ethics* V, Prop. III. Boyle, p. 203.)

The next philosopher who dealt in any way with mental activity outside of consciousness was Immanuel Kant (1724-1804). Hartmann[20] paid tribute to Kant, and on the first page of the *Philosophy of the Unconscious* (*infra*), he acknowledged his indebtedness to "the great clear thinker of Königsberg." On page 20, Hartmann quoted from Kant's *Anthropology* (1798), Section 5: "Innumerable are the sensations and perceptions *whereof we are not conscious,** although we must undoubtedly conclude that we have them, obscure ideas as they may be called (to be found in animals as well as in man). The clear ideas, indeed, are but an infinitely small fraction of these same exposed to consciousness. That only a few spots on the great chart of our minds are illuminated may well fill us with amazement in contemplating this nature of ours." Kant's writings are complicated and tedious to read, and even his scholarly admirers find him difficult. For instance, F. Max Müller wrote that he hoped his English translation of the *Critique of Pure Reason* (1781)[21] would be more intelligible to students than the German original!

However, a few passages from the *Critique*[21] which are pertinent to the subject should be mentioned: "We shall see hereafter that synthesis in general is the mere result of what I call the faculty of imagination, a blind but indispensable function of the soul, without which we should have no knowledge whatsoever, *but of the existence of which we are scarcely conscious.** But to reduce this synthesis to concepts is a function that belongs to the understanding, and by which the understanding supplies us for the first time with knowledge properly so called (p. 64). . . . This representation of a general procedure of the imagination by which a concept receives its image, I call the schema of such a concept.

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"The fact is that our pure sensuous concepts do not depend on images of objects, but on schemata (p. 115). . . . this schematism of our understanding applied to phenomena and their mere form is an art *hidden in the depth of the human soul,** the true secrets of which we shall hardly ever be able to guess and reveal" (p. 116).

Of all the philosophers, the one who probably should receive most credit for his conception of an unconscious was Arthur Schopenhauer (1788-1860). At least he is "easy to read," which is more than can be said for most of the rest of them! Even Sigmund Freud, in *The History of the Psychoanalytic Movement*,[22] following up a paper by Otto Rank[23] was obliged to acknowledge Schopenhauer's lead in dealing with the mechanism of repression. In *Die Welt als Wille und Vorstellung*[24] which was first published in 1819, the following passage occurs: "The exposition of the origin of madness in the text will become more comprehensible if it is remembered how *unwillingly** we think of things which powerfully injure our interests, wound our pride, or interfere with our wishes; with what difficulty do we determine to lay such things before our own intellect for careful and serious investigation; how easily, on the other hand, *we unconsciously break away or sneak off from them** again; how, on the contrary, agreeable events come into our minds of their own accord, and, if driven away, constantly creep in again, so that we dwell on them for hours together. In that resistance of the will to allowing what is contrary to it to come under the examination of the intellect lies the place at which madness can break in upon the mind. Each new adverse event must be assimilated by the intellect, *i. e.*, it must receive a place in the system of the truths connected with our will and its interests, whatever it may have to displace that is more satisfactory. Whenever this has taken place, it already pains us much less; but this operation itself is often very *painful*,* and also, in general, only takes place slowly and with *resistance*.* However, the health of the mind can only continue so long as this is in each case properly carried out. If, on the contrary, in some particular case, the resistance and struggles of the will against the apprehension of some knowledge reaches such a degree that that operation is not performed in its integrity, then certain events or circumstances become for the intellect completely *suppressed*,* because the will cannot endure the sight of them, and then, for the sake of the necessary connection,

* Italics the present writer's.

the gaps that thus arise are filled up at pleasure; thus madness appears. For the intellect has given up its nature to please the will: the man now imagines what does not exist. Yet the madness which has thus arisen is now the lethe of unendurable suffering; it was the last remedy of harassed nature, *i. e.*, of the will. . . . In accordance with the above exposition one may thus regard the origin of madness as violent *'casting out of the mind'** of anything, which, however, is only possible by 'taking into the head' something else" (Vol. III, pp. 168-9). This statement is so clear it requires no further explanation.

Schopenhauer wrote in other pages of an unconscious mental activity: ". . . let us compare our consciousness to a sheet of water of some depth. Then the distinctly conscious thoughts are merely the *surface*;* while, on the other hand, the indistinct thoughts, the feelings, the after sensation of perceptions and of experience generally, mingled with the special disposition of our own will, which is the kernel of our being, is the *mass** of the water. Now the mass of the whole consciousness is more or less, in proportion to the intellectual activity, in constant motion, and what rise to the surface, in consequence of this, are the clear pictures of the fancy or the distinct, conscious thoughts expressed in words and the resolves of the will. The whole process of our thought and purpose seldom lies on the surface, that is, consists in a combination of distinctly thought judgements; although we strive against this in order that we may be able to explain our thought to ourselves and others. But ordinarily it is in the obscure depths of the mind that the rumination of the materials received from without takes place, through which they are worked up into thoughts; and it goes on almost as *unconsciously** as the conversion of nourishment into the humours and substance of the body. Hence it is that we can often give no account of the origin of our deepest thoughts. They are the birth of our mysterious inner life. Judgements, thoughts, purposes, rise from out that deep unexpectedly and to our own surprise. . . . Consciousness is the mere surface of our mind, of which, as of the earth, we do not know the inside, but only the crust.

"But in the last instance, or in the secret of our inner being, what sets in activity the association of thought itself, the laws of which were set forth above, is the *will*, which urges its servant the

* Italics the present writer's.

intellect, according to the measure of its powers, to link thought to thought, to recall the similar, the contemporaneous, to recognize reasons and consequents" (Vol. II, p. 327).

The analogy of the mind to a body of water, the thin surface being conscious and the vast deep being unconscious, is interesting, because in many theories of the unconscious the same general theme of stratification has been applied. Probably the most common one is the "iceberg theory," conscious mind activity being the one-ninth of the iceberg above water level, and unconscious being the eight-ninths below the surface. This idea has been ingeniously reapplied lately by J. S. L. Browne in his concept of disease causation which he elaborated in attempting to explain the action of ACTH.[25] Schopenhauer wrote elsewhere: "The will, as the thing in itself, constitutes the inner, true, and indestructible nature of man; in itself, however, it is *unconscious.** For consciousness is conditioned by the intellect, and the intellect is a mere accident of our being; for it is a function of the brain, which, together with the nerves and spinal cord connected with it, is a mere fruit, a product, nay, so far, a parasite of the rest of the organism; for it does not directly enter into its inner constitution, but merely serves the end of self-preservation by regulating the relations of the organism to the external world" (Vol. II, p. 411). Emotion was considered an inclination which exercised a power over the will (Vol. III, p. 407).

After Schopenhauer, a very significant advance was made by Johan Friedrich Herbart (1776-1846),[26] who attempted to form a mathematical, scientific, and dynamic foundation for philosophy and psychology. He described how ideas came into consciousness and then passed away into the unconscious. Ideas might co-exist in consciousness or might strive against one another (conflict) and exclude others from consciousness (repression). The ejected ideas did not remain passively in the unconscious, but tried at all times to regain conscious standing. He wrote at length on "the threshold of consciousness," and described two levels, the statical and mechanical.

This very important theory allowed for unconscious concepts that affect conscious mental activity. These points will be clear from the following passages from Herbart's *Lehrbuch zur Psychologie* (1st ed. 1816; 2nd 1834. The translation of the latter[26] is quoted): ". . . concepts must be regarded as forces whose ef-

*Italics the present writer's.

fectiveness depends upon their strength, their oppositions, and their combinations, all of which are different in degree (p. 6). . . . Concepts become forces when they resist one another [c. f., *conflict*].* This resistance occurs when two or more opposed concepts encounter one another (p. 9). . . . .When a sufficiency of opposition exists between concepts, the latter are in equilibrium [c. f., *homeostasis.*]* They come only gradually to this point. The continuous change of their obscuration may be called their movement (p. 11). . . . A concept is in consciousness in so far as it is not suppressed, but is an actual representation. When it rises out of a condition of complete suppression, it enters into consciousness. Here, then, it is on the threshold of consciousness (p. 13). [This is later distinguished as the statical, as opposed to the mechanical threshold]* . . . When to several concepts already near equilibrium [c. f., *homeostasis*]* a new one comes, a movement arises which causes them to sink for a short time beneath their statical point, after which they quickly and entirely of themselves rise again—something as a liquid, when an object is thrown into it, first sinks and rises . . . one of the older concepts may be removed entirely out of consciousness even by a new concept that is much weaker than itself. In this case, however, the striving of the suppressed concept is not to be considered wholly ineffective . . . it works with all its force against the concepts in consciousness. Although its object is not conceived, it produces a certain condition of consciousness. The way in which these concepts are *removed out of consciousness and yet are effective therein*** may be indicated by the expression, 'They are on the mechanical threshold.' The threshold mentioned above is called for the sake of distinction the statical threshold. Note—If the concepts on the statical threshold acted in the same way as on the mechanical threshold we should find ourselves in a state of the most intolerable uneasiness, or rather the body would be subjected to a condition of tension that must in a few moments prove fatal, even as under present conditions sudden fright will sometimes cause death; for all the concepts which, as we are accustomed to say, the memory preserves, and which we well know can upon the slightest occasion be reproduced, are in a state of incessant striving to rise, although the condition of consciousness is not at all affected by them" (p. 18).[26]

*Present writer's comment.

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Karl Gustav Carus (1789-1869), professor at Dresden, wrote extensively on magic, animal magnetism, and the unconscious, "the night side" of the soul. In 1846, in *Psyche: zur Entwickelungsgeschichte der Seele,*[27] on page 1, he wrote as follows: "The key to the recognition of the substance of the conscious soul life lies in the region of the unconscious" (*Der Schlussel zur Erkenntniss vom Wesen des bewussten Seelenlebens liegt in der Region des Unbewusstseins*). Carus is very important to the subject of the present paper because of his use of a theory of the unconscious to investigate the common ground of philosophy and abnormal psychology (unusual mental states, magic, hypnosis).

So far, the German philosophers have been discussed at length, and it might be refreshing for a change to speak of a Scottish one, Sir William Hamilton (1788-1856), professor of logic and metaphysics at Edinburgh. He formulated the idea of "mental latency," which Mill[28] agreed with in principle but preferred to apply on a neurological basis. Hamilton's *Lectures on Metaphysics* were published posthumously by Mansel and Veitch.[29] Three different kinds of "latency" were propounded by him, and they are of great interest since he applied one type to abnormal mental states.

(1) ". . . the riches—the possessions, of our mind, are not to be measured by its present momentary activities, but by the amount of its acquired habits. I know a science, or language, not merely while I make a temporary use of it, but inasmuch as I can apply it when and how I will. Thus the infinitely greater part of our spiritual treasures, lies always beyond the sphere of consciousness, hid in the obscure recesses of the mind" (Vol. I, p. 339).

(2) ". . . when the mind contains certain systems of knowledge, or certain habits of action, which it is wholly unconscious of possessing in its ordinary state, but which are revealed to consciousness in certain extraordinary exaltations of its powers. The evidence on this point shows that the mind frequently contains whole systems of knowledge, which, though in our normal state they have faded into absolute oblivion, may, in certain abnormal states, as madness, febrile delirium, somnambulism, catalepsy, & c., flash out into luminous consciousness, and even throw into the shade of unconsciousness those other systems by which they had, for a long period, been eclipsed and even extinguished" (p. 339).

(3) "Are there, in ordinary, mental modifications,—i. e. mental activities and passivities, of which we are unconscious, but which

manifest their existence by effects of which we are conscious? . . . In the question proposed, I am not only strongly inclined to the affirmative,—nay, I do not hesitate to maintain, that what we are conscious of is constructed out of what we are not conscious of,—that our whole knowledge, in fact, is made up of the unknown and the incognisable" (p. 347).

The most broadly developed theory of an unconscious ever worked out was propounded by the German philosopher, Eduard von Hartmann (1842-1906) who, when only 27 years of age, in 1868, published the phenomenal three-volume work, *Philosophie des Unbewussten* (*Philosophy of the Unconscious*), which had a profound effect on the thought of man during the nineteenth century. Certainly most medical men of that time were familiar with it. The book was translated into English in 1884,[20] and is readily available, but it is surprising how few modern psychiatrists know about it. If this paper has no other effect than to stimulate some colleagues to thumb through Hartmann, the writer will feel that he has done a useful service. Hartmann was strongly influenced by Kant, as previously mentioned, and wrote (Ref. 20, p. 17) of Leibniz "making the discovery of unconscious ideas." Hartmann assigned to the unconscious a much more important place than any previous writer. For him, it was a combination of unconscious will (cf. Schopenhauer) and unconscious idea (cf. Aristotle). Unconscious feeling, so important to modern psychological theory, he resolved into the other two elements. Hartmann unnecessarily applied his idea of the unconscious to explain many an aspect of life which could more appropriately be explained otherwise. His generalizations were broad enough to be described as "cosmic" in scope, and he has been severely criticized because of this. However, one is obliged to give this man his due; he was a pioneer, and his work is a landmark in the history of philosophy and psychology. It is appropriate that a discussion of the philosophers who have written concerning the unconscious ends with the name of Hartmann.

G. Psychology and Medicine

Excluding the advances of the last 50 years, the works of psychologists, physiologists and medical men have not contributed so much to unconscious theory as those of the philosophers. However, a few names may be mentioned. The early work in these

fields came, not out of Germany, as had the philosophy, but from Scotland and France.

Robert Whytt (1714-1766), in *An Essay on the Vital and Involuntary Motions of Animals* (1750),[30] wrote: ". . . when we are solicitously engaged in any action, involved in any thought, or hurried away by any passion, we may be *unconscious** of the impressions made by material causes on the organs of sense; yet we cannot but be sensible of the ideas formed within us by the internal operation of our minds, because their very existence depends upon our being conscious of them, and it is at an end, as soon as either we attend not to, or forget them: to say therefore that such ideas may be formed and exist in the mind without consciousness, is, in effect, to say that they may and may not exist at the same time" (Ref. 30, p. 151). He added a footnote: "To avoid all metaphysical disputes about different degrees of consciousness, I desire it may be understood, that here and in other parts of this essay, when I say we are not conscious of certain impressions made on the mind by the action of material causes on the organs of the body, I mean no more, than that we have no such consciousness or preception of them, as either convinces us of their existence when present, or enables us, by the help of memory, to recall them when past."

The great William Cullen (1710-1813),[31] who succeeded Whytt at Edinburgh, wrote: "Many impressions have their effects without sensation or volition" (Ref. 31, p. 93). These two men anticipated by a century the physiological research of Fechner ("unconscious sensations"), Wundt ("unconscious inferences"), Helmholtz, and others.

In Germany, Ernst Platner (1744-1818), professor of physiology at Leipzig, was influenced by the philosopher Leibniz, and maintained the presence of unconscious elements in thought *and feeling* (Ref. 15, Vol. II, p. 322).

In France, Pierre-Jean-Georges Cabanis (1757-1808) wrote of *"sensibilité sans sensation"* or *"impressions dont l'individu n'a nullement la conscience."*[32a] He formulated a hierarchical "level" theory of nervous action and a "destruction-reproduction" hypothesis, which were rediscovered by John Hughlings Jackson almost a century later.

*Italics the present writer's.

For Cabanis, the spinal cord carried out reflex acts in response to stimulation. At a higher level, semiconscious and semi-integrated activities took place: This was the center for vital and instinctive faculties. At the uppermost level, in the brain cortex, complicated functions, such as thought and volition, were located.

In his *Coup d'oeil sur les Révolutions et sur la Réforme de la Médecine* (1804),[32b and c] he wrote: "Observe that youth, who haunted by a vague uneasiness, continually absorbed in revery, and melted to tears by the slightest emotions, begins to find ideas in his imagination, and desires in his heart, which, before, were unknown" (Ref. 32c, p. 308). Here one sees an insight into the awakening of instinctual drives at puberty, and intimation of a knowledge of unconscious ideas and emotions. He wrote of "inert" or "unknown" ideas and passions.

François-Pierre-Gonthier Maine de Biran (1766-1824),[33] a contemporary of Cabanis, clearly distinguished levels of mental activity. Below consciousness, where intellect and reason held sway, he placed a stratum which was out of voluntary control, a region where passion reigned supreme. He described how the latter asserted itself in dreams and moments of inattention. Maine de Biran analyzed consciousness by comparing it to the center of a circle, from which unconscious processes radiated, becoming fainter as they receded from the center. This was an identical simplification to that which Paul Carus used in explaining what he called central (conscious) and peripheral (unconscious) soul life.[34]

In Germany, Friedrich Eduard Beneke (1798-1854) formulated his doctrine of "traces," which closely resembled the theory of Herbart, with which it was contemporaneous. No activity of the mind was ever completely lost. The disappearance of every idea from consciousness left a trace, which served as a basis for subsequently coming back into mind.[15, 35]

After the 1820's, the theory of unconscious mental action became widespread in psychology and medicine. One reason for this was an increased interest in hypnosis, which was due in large part to Alexis Bertrand, John Elliottson, James Esdaile, and particularly James Braid, who published his book *Neurypnology* in 1843. These men, and others of course, were responsible for the growth of crude animal magnetism into scientifically acceptable hypnosis, free of mystery and humbug. The research in hypnotism naturally led to the investigation on a scientific basis of unusual states

of consciousness such as trances, fugues, and automatic behavior, and to the mechanisms involved in the genesis of neuroses. Sleep, dreams, and somnambulism also came to merit more attention from physicians.

As representative, one may note the work of John Abercrombie (1781-1844)[36] and Robert Macnish (1802-1837).[37] Abercrombie, in his *Inquiries Concerning the Intellectual Powers* (1830), had much to say on association *without consciousness* (Ref. 36, p. 110). What had previously been wordily stated in philosophy, he elaborated into clear and concise medical diction.

Macnish, in discussing dreams, wrote: "When, however, one faculty [i. e., of mind] or more than one, bursts asunder the *bonds** which enthralled it, while its fellows continue chained in sleep, then visions ensue, and the imagination dwells in *that wide empire which separates the waking state from that of perfect sleep** . . . the imagination is at work, while the judgment is asleep; and thereby indulges in the maddest and most extravagant thoughts, free from the salutary check of the latter more sedate and judicious faculty" (Ref. 37, p. 52). One sees here an understanding of unconscious fantasy life, strong in emotional tone and short on intellectual control.

Toward the middle of the nineteenth century, the unconscious took on a neurological veneer which was in keeping with the somatic orientation of the day. Notable was the work of Thomas Laycock (1812-1876), who was physician to the York dispensary, and Wilhelm Griesinger (1798-1868), professor of mental science at Berlin. In the early 1840's they both developed the concept of "reflex activity" of the brain. Laycock[38] wrote on "reflex function of the brain," and also of the "substrata [i. e., ideagenic and kinetic]** of psychical phenomena": ". . . these substrata may be persistent as a part of the organism, and continue to be manifested by acts long after the necessity for those acts, as conservative of the individual or race, has ceased . . . these substrata may be dormant for a lengthened period from the want of a reagent, and appear extinct, but will reappear so soon as the impressions adapted to their action are received by and conveyed along the afferent nerves" (p. 308). Griesinger[39] wrote of "psychic reflex action," which apparently was meant to describe the same sort of thing.

*Italics the present writer's.

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This whole neurological approach culminated in the "unconscious cerebration" of the physiologist, William Benjamin Carpenter (1813-1885). In 1852, he wrote[40] of "unconscious storing up of impressions," which could only be brought to consciousness by the connecting link of associations (p. 783), and he included the emotional factor: ". . . it must not be left out of view that *emotional* states, or rather states which constitute emotions when we become conscious of them, may be developed by the same process . . ." etc. (p. 791).

One should mention Sir Benjamin Collins Brodie (1783-1862),[41] the great surgeon who was so interested in psychology—most unusual for a surgeon! This man carried out fundamental observations on the somatic symptoms of hysteria, and pointed out that the condition was not a result of observable pathological changes in the brain or spinal cord. He wrote: "mental operations of which we seem to be unconscious" (Ref. 41, p. IX), and ". . . as if there were in the mind a principle of order which operates without our being at the time conscious of it . . ." (p. 20).

The discussion would not be complete without reference to Henry Maudsley (1835-1918).[42] He had a very clear formulation of unconscious mental activity which included both ideation and emotionality. He explained everything on a neurophysiological basis.

In Maudsley's *Physiology and Pathology of Mind* (1867) we read: "It is a truth which cannot be too distinctly borne in mind, that consciousness is not co-extensive with mind. From its first moment of its independent existence the brain begins to assimilate impressions from without, and to re-act thereto in corresponding organic adaptations; this it does at first without consciousness, and this it continues to do unconsciously more or less throughout life. Thus it is that mental power is being organized before the supervention of consciousness, and that the mind is subsequently regularly modified as a natural process without the intervention of consciousness. The preconscious action of the mind, as certain metaphysical psychologists in Germany have called it, and the unconscious action of the mind, which is now established beyond all rational doubt, are assuredly facts of which the most ardent psychologist must admit that self-consciousness can give us no account (p. 15). . . . Anything which has existed with any completeness in consciousness is preserved, after its disappearance therefrom, in the mind or brain, and may reappear in consciousness at some fu-

ture time. That which persists or is retained has been differently described as a residuum, or relic, or trace, or vestige or again as potential, or latent, or dormant idea; and it is on the existence of such residua that memory depends. Not only definite ideas, however, but all affections of the nervous system, feelings of pleasure and pain, desires, and even its outward reactions, thus leave behind them their residua, and lay the foundations of modes of thought, feeling and action . . ." (p. 15).

H. After 1850

It would be out of place to include Sigmund Freud's contributions to unconscious theory in a historical discussion, and the same may be said of Carl G. Jung's (the *collective* unconscious). However, in addition to the numerous authors discussed here at length, a large number of others have at some time or another, prior to or very soon after the turn of the present century, indicated in their writings that they were familiar with unconscious mind action. It might be interesting to list a few of them as follows in alphabetical order:

Ach, N.
Barrett, W. F.
Bascom, J.
Bastian, H. C.
Bergson, H.
Bernheim, H.
Binet, A.
Bleuler, E.
Breuer, J.
Brierre de Boismont, A. J. F.
Bröchner, H.
Butler, S. (unconscious memory)
Carlyle, T. (unknown deep)
Carrière, M.
Carus, P. (peripheral soul life, the unconscious)
Cobbe, F. P.
Creighton, C.
Dessoir, M.
Faraday, M.
Fechner, G. T. (unconscious psychical processes, sensations, ideas)
Feuchtersleben, E.
Freud, S.
Galton, F. (antechamber of consciousness, deeper strata)
Gorton, D. A.
Grasset, J.
Helmholtz, H. L. F. (unconscious inference)
Hering, K. E. K.
Höffding, H.
Holland, H. (dislocated memory)
Holmes, O. W.
Ideler, C. W.
Ingersoll, A. J.
Jackson, J. H. (theory of levels)
James, W. (subconscious incubation, extramarginal consciousness)
Janet, P. (*idées fixes*, subconscious, secondary consciousness, dissociation)
Jastrow, J.
Jung, C. G. (collective unconscious)
Koch, J. L. A.
Kretschmer, E. (sphaira)
Lange, C. G.
Lazarus, M.
Lewes, G. H.
Lotze, R. H.
Morgan, C. L. (infraconsciousness)
Myers, F. W. H. (subliminal consciousness)

Nietzsche, F.
Page, C. W.
Perty, J. A. M.
Porter, N.
Prince, M. (co-conscious)
Ribot, T. A. (preconscious, unconscious)
Richer, C. R.
Richter, J. P. F.
Schelling, F. W. J.
Schindler, A.
Schofield, A. T.
Scott, W.
Sidis, B.
Stout, G. F.
Sully, J.
Tuke, D. H.
White, T. G.
Whittaker, T.
Wundt, W. (unconscious inference, unconscious soul)
Zeller, A.
Zöllner, F.

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EDITORIAL COMMENT

CONCERNING A DUSTY ANSWER

One can be too "hot for certainties in this our life!" And some of us appear hot for a certainty that is not to be found in psychiatric, medical or any other science.

There are probably as many definitions of science as there are scientists. To Abraham Flexner, science may be "the severest effort capable of being made in the direction of purifying, extending and organizing knowledge." Sir William Dampier defines it as "ordered knowledge of natural phenomena and of the relations between them." Webster's *New International Dictionary* says in part that it is "accumulated and accepted knowledge which has been systematized and formulated with reference to the discovery of general truths or the operation of general laws"; and the dictionary goes on to cite Karl Pearson's remark that science "may be described as a classified index to the successive pages of sense impression which enables us readily to find what we want, but it in no wise accounts for the peculiar contents of this strange book of life."

We read in all this no use of the term "certainty" which is something one finds once in the dictionary, frequently in theology, and seldom or never in life. Knowledge is something else. Knowledge is not certainty but is acquaintanceship with the facts, as we conceive of the facts. (Whatever the objective truth may be, it must always be screened for man by man's concept of the facts.) The whole history of science has involved constant shifting in concepts of the facts. Early man had a respectable body of accumulated and accepted knowledge which he had systematized and formalized to a very great extent in his attempt to discover truths and determine the operation of natural laws. His efforts deserve to be called the beginning of science—as well as the beginning of religion, for the hypotheses he adopted to explain what he failed to understand developed into primitive religions all over the world, and ultimately into such advanced religious systems as those of India, ancient Greece and ancient Rome.

But early man's concepts of what he observed were faulty and his hypotheses childish. He observed the sun rise in the east and

set in the west; and he conceived that the sun moved across a solid firmament above the earth, or, as his understanding developed, in a circular orbit around it. He saw the stars, fixed in their pattern, night after night and year after year, turn nightly about the pole, and he conceived of them, too, as fixed lights set in a solid canopy.

We see in the sky largely what early man saw except that his north star was likely Vega, or maybe *alpha* Draconis, not necessarily our Polaris. But concepts about what we see have changed. Yet we make use of much of it for the same purpose and in very much the same way that our remote ancestors did. It would be stupidly untruthful to deny that they, like us, made scientific observations and employed them for scientific purposes.

The present comment is inspired by two scientific articles in the October 1952 issue of THE PSYCHIATRIC QUARTERLY, "Patterns of Research in Mental Hygiene" by Benjamin Pasamanick and "Some Recent Trends in Organized Psychiatry" by Daniel Blain, to the latter of which we are indebted for the definition of science cited from Abraham Flexner. Dr. Pasamanick, in a discussion much of which we applaud heartily and with some of which we agree without reservation, concludes that mental hygiene (and presumably psychiatry as a whole) "ought to try to find answers to questions for which definitive answers are possible. . . ." Dr. Blain says frankly, "I worry about myself sometimes because of constantly believing things of which I see no definite proof . . .," but he cites Flexner's stress on "observation, inference, verification, generalization" to justify his own belief that "if psychiatry, as part of medicine" will recognize the necessity to be both artistic and scientific and will work for the development of tools to measure observations and compare them, "we will proceed and make further advances."

Between restricting its principal endeavors to questions for which definitive answers are possible, and working for the development of tools for use in psychiatric fields where "definitive answers" or "definite proof" are not yet possible, we think psychiatry must choose the latter course if it is not to put a period to all its progress as a science. But to make clear what we are striving for, we think, first of all, we should endeavor to present some idea of what is a definite proof or definitive answer. In one application, we think, and in one of importance to this discussion, there is no

such thing as a definitive answer in a scientific sense to any question in science. That is, we can know nothing, or virtually nothing, with absolute certainty unless we also have knowledge of the ultimate—knowledge of the cause of causes. Neither our five senses nor our reason commands the ultimate or offers any prospect of ever commanding the ultimate. And if they could, if we could trace cause and event with certainty back to first cause, we should come to the difficulty again of the limitations of human concept, human comprehension.

Science can no longer turn to theology for a basis of certainty; the long histories of science and theology have demonstrated no necessary conflict but have equally demonstrated that though they stand on common ground in the service of God and man, they are not and cannot be interdependent. Theology finds its certainties in its own way; science must be content with an ultimate uncertainty, beyond which is an ultimate unknown. A necessity of science is readiness to admit new evidence, accept new facts, test new hypotheses, work in accordance with new theories. Robert Heinlein, who specializes in fiction of the hypothetical future, makes one of his young characters remark ". . . if the course we had in the history of science means anything at all, it means that scientists change their theories about as often as a snake changes his skin. . . ." Well, from our point of view, perhaps not quite so often.

But from any honest scientist's point of view, theories do and must change as information accumulates. Consider astronomy. Although the correct heliocentric theory of the "universe" had been suggested long before the time of Ptolomy, who lived in the second century of our own era, man did not yet have the optical instruments or the mathematical concepts to support it; and Ptolomy's quite wrong geocentric theory was good science in the light of his day. It appeared to conform, for example, to his own sound, scientific principle, that is, in general, that in seeking to explain phenomena, one should adopt the simplest explanation in accordance with the observed facts. And wrong as the Ptolomaic theory was, it served the world as a useful tool of science for more than 13 centuries—into the age of the great voyages of exploration.

Similarly, Newton's formulations of the laws of gravitation served man for two centuries and still serve him in ordinary calculations, although Einstein and others have long since proved

that they are not even approximations of what we now conceive to be the truth about the universe. A scientific law is, of course, not a law in the sense in which the word "law" is otherwise used. It is a descriptive statement of what we think happens in the world as we see it under given circumstances; or it may be a mathematical or other formula covering such a description. Any scientific law may be proved incorrect, and none is immutable. Lancelot Hogben, whose politics are to be deplored but whose scientific acumen is considerable, states the case in *Mathematics for the Million*: "A scientific law is an approximate truth, and can only be used with safety when we know the limits within which it works sufficiently well for our requirements." Mathematics itself, sometimes regarded as the "purest" of the scientific disciplines, is based fundamentally on a series of entirely human definitions and assumptions—definitions and assumptions existing only in the mind of the mathematician. And as the mathematician has applied his "pure" mathematics to "actual" problems, he has been forced to new definitions and assumptions. For instance, to describe and understand by measurement the physical phenomena and the processes of the world today, as we see them or think we see them, the mathematician has resorted, among many other things, to "drunk" or "imaginary" numbers which, according to the old definitions and assumptions, simply cannot exist.

This discourse is by way of illustrating that science has, or claims, no certainty at its very foundations. Space-time appears to be a continuum, but we are uncertain of its nature and utterly ignorant of its cause—or if it has a cause. The quantum theory has cast new light on the structure of the atom and has demonstrated the "uncertainty principle" at the same time: that is, that there is a limit to the precision with which scientists can observe nature. $E=mc^2$ appears to describe approximately the process by which the uncounted suns of uncounted galaxies produce energy, and the atom and hydrogen bombs are experimental demonstrations of the formula. But this observation does not explain why. And it is not beyond the bounds of theoretical possibility that it is as wrong as the Ptolomaic, geocentric theory of the universe—a useful concept, one leading to scientific advance, perhaps incorrect on the basis of future evidence, but the best we can do at the time. We might believe we knew a little more if we could settle

the unified field problem; that is, agree with Einstein or others on the characteristics of a unified field or single background for all physical activity—but we still would not know why.

If the whole tremendous pyramid of science is thus built on a foundation of the unknown or the doubtful, it is difficult to produce a good reason for medicine or psychiatry or any other specialty to limit its inquiries simply because its particular foundation includes more of the same. We know a great deal about inorganic matter, meaning again by "know" that we are well acquainted with a great many facts as we conceive of the facts. We know, similarly, a great deal about life and about specific living organisms. But we do not know the connection—and from the rest of science we must presume there to be one—between life and lifelessness, organic and inorganic. We believe we know something about the conditions under which life appeared or was created; but we haven't succeeded in evoking its appearance or creation by duplicating those conditions; and we are not certain that conditions undreamed of on our planet and impossible to duplicate here might not also produce a phenomenon we would term life, though perhaps on a totally different basis than our own. We don't even know what life is; the dictionary calls it, among much verbiage, a quality or character which distinguishes the living from the inorganic or the living from the organic dead, and which is manifested by certain qualities such as metabolism, growth and reproduction. This is pure description in the sense that it depicts something we cannot understand in the way of tracing from inorganic cause to organic effect—as we can trace cause and effect in inorganic science. And we think it adds little or nothing to call life in more scientific terms a function. Yet the whole of medical science, with its manifold specialties, is devoted to the preservation, prolongation and improvement of this uncomprehended thing called life.

The medical specialty of psychiatry is separated from general medicine by a second gap between the known and the unknown. As far as science is concerned, mind has much the same relation to life and living matter as life itself has to inorganic matter. One presumes there is a connection; in fact, we know of no scientist who would not insist vigorously on the necessity of a connection; but we are ignorant of its mechanism and of the conditions under which it operates. The psychiatrist thinks of mind as something intangible in which thought and emotion originate or manifest

themselves; sometimes he finds it convenient to assume that mind is an organ of the body; or he may think of it as a function of the central nervous system; or he may—some do—think of mind and body as a full dichotomy, the body acting as host for the unrelated mind only during maintenance of certain bodily life-functions.

We know some of the aspects and capabilities of intellect, but not its derivation; we may know a little more—but only a little more—about the relation of emotion to bodily structure and function. But by and large, we cannot trace mental phenomena to their somatic expressions or origins. We once believed we could localize the physical expression of certain mental functions in the brain, as we can localize areas of the physical senses, such as those of sight and smell; but experience with lobotomy and topectomy, as well as with occasional lobectomy, suggests that some of our confidence may have been misplaced.

The nature of the mental function known as consciousness (particularly in the form of self-awareness) may illustrate the uncomprehended; it is difficult to define satisfactorily, difficult to relate to other mental content, and baffling when one seeks its somatic representation. We do not even know how closely consciousness and other "higher" human mental attributes are associated with the forebrain, or whether they are shared—and if so to what extent—by other participants in the earth's drama of life. The comparative psychologists give us no answer to this.

But if we do not know the cause of mind, or its origin, or all its somatic representations, we do know a great deal about the mind itself. The mind has been the object of study and speculation as long as the body; we suspect the first man, like infants or some psychotics, had difficulty in distinguishing among mind-body-environment phenomena. Early medicine derived from early magic; it probably was directed quite as often toward mental relief as bodily; general medicine and psychiatry have inherited time-tested empiric practices in the field of mind, including the placebo, hypnosis and suggestion.

We know something of the capacities of the human mind. We know that all artifacts from the first flint arrowhead to the contents of the Library of Congress are products of the human mind. We know that at least one science, and that of tremendous importance, pure mathematics, originated in and exists in the human mind—without regard to applications to anything known or imagined in

heaven or earth. And we know that the modern results of this science—to the layman, inconceivably abstruse mentation—have contributed vastly to the understanding of all the closer-to-earth sciences and to the creation of modern technicological civilization generally.

We also have a good deal of descriptive material—and descriptive material is the basis of much non-medical science also—about mental derangement, dating from early times. King Saul was plainly a melancholiac; the behavior of the great Nebuchadnezzar, if the testimony of his jaundiced Hebrew enemies can be trusted, is consistent with a modern diagnosis of schizophrenia. We have known the general patterns of derangement for thousands of years. With all this, it is admittedly true, as Pasamanick points out, that our clinical diagnoses show such lack of consistency and uniformity that—as compared from state to state; we might add, perhaps, even from hospital to hospital—they are unsuitable for epidemiologic studies. We do not think, however, that this deplorable nosological confusion is warrant for abandoning either empirically- or theoretically-established psychotherapeutic treatment, or for throwing up our hands in despair about the possibilities of research. Rather, we think, diagnosis is something for the American Psychiatric Association and the administrators of the federal and state mental hospital systems to get together on and straighten out —with private practice well represented. The observance of uniform but doubtful categories will certainly leave much to be desired; but the general observance of almost any definite categories whatever should assist the epidemiologist and should not interfere with research, which—contrary to some opinion—we think is in a presently promising state.

The great difficulty—and we wonder if it is not an emotional as well as an intellectual difficulty—in studying the mind, is that mind itself must observe and study mind. Mind cannot be seen, touched, tasted, heard or smelled: it must observe and correlate its observations by special sense of its own. (We are aware, of course, that it employs the bodily organs and senses for this purpose.) Mind seems less real to many persons than phenomena which are detectable by the senses. One cannot watch it, perform surgery on it, dose it with cathartics, or take its temperature. One can only gauge it by studying it with another mind.

We are very far from suggesting that desire for something more nearly tangible forms Pasamanick's thesis; we don't believe it for an instant, although from the point of view of epidemiology he would like to have something he can measure; and nobody can blame him. But we do think his argument will appeal to those who particularly desire to apprehend, with the five bodily senses, what they are doing—the miscalled realists. And we think there is always a temptation to evaluate the real but intangible as something less than the real but tangible, a temptation known to all medical people, who have progressed through dissecting rooms to practise physical, tangible medicine and surgery on physical, tangible, living persons. We think it would be a great disservice to psychiatry should such a trend become dominant or even spread.

General medicine has been forced to treat living beings without being able to establish what life is or how it originates. We do not think it astonishing if psychiatry has been forced, likewise, to treat mind without knowing what mind is or how it originates. And we do not see that the one procedure is any less scientific than the other.

The problem of life is one for which we doubt there will be a solution in the presently predictable future. So, likewise, is the problem of mind. We do not think we should give up the practice of medicine because there is an unknown factor at its base, an unknown step in the scientific structure of causality. And likewise, we think we should maintain the practice, and continue to investigate the theory, of psychotherapy.

We do not believe, either, that we should give up the search for causality between mind and its somatic background. We believe firmly on theoretical grounds and because of repeated demonstrations of unknown links, or mechanisms of causality—clinically and experimentally—that psyche and soma are different facets of the same thing. Freud, whose work gave impetus to practically all modern schools of psychodynamics, even to those which disagree most emphatically with him, believed in a somatic basis for psychic disorder. And psychiatrists generally certainly see every reason to assume that psychic disturbance has its somatic counterpart. The fact can be observed clinically and experimentally any day.

If we can determine the mechanism or mechanisms by which this psychosomatic interrelationship takes place, we certainly should

spare no effort which is even remotely likely to do so. And so we are in full agreement with such suggestions as that advanced by Pasamanick for a controlled study in some undernourished population of the earth to see what effects an adequate supplementary diet for pregnant women would have on the growth, development and behavior of their offspring. He reports one exceedingly interesting and significant study which points to the importance of inquiry along these lines—a study which revealed that a large sample of New Haven Negro infants examined in 1944 were (somewhat unexpectedly) found equal behaviorally and intellectually to comparable groups of white children and to the New Haven white children upon whom norms had been established. Since they were also equal physically, in contrast to the usual lower birth lengths and weight curves of Negro infants, it was hypothesized that improved nutrition of their parents during wartime and under rationing had something to do with their good mental performance.

Psychiatry has everything to gain from research which may establish such psychosomatic links, though in the instance cited, the connection seems to be between nutrition and intellect, rather than between any physical factor and any clearly established dynamic one. We are also—and it shouldn't be necessary, but probably is, to say so—thoroughly in favor of such investigations into genetics as Kallmann's twin studies; in favor of continued vigorous inquiry into the psychosomatic ramifications of shock, psychosurgery and other physical and surgical therapies; and in favor of such work as the endocrine research currently being done at Creedmoor by the Sacklers. We are in favor of these things, even though the establishment of relationship in one or more of them might still leave gaps to close. We have a fully established relationship between organic brain damage in such entities as syphilitic meningoencephalitis and arteriosclerosis, and the personality damage reflected in general paresis and in the psychosis which accompanies arteriosclerosis. But we still have not the slightest idea of how electro-chemical action in a damaged brain is transmuted into psychotic reaction. And we see, still without understanding, a contrary process demonstrated in the shock therapies. We think that, beyond much doubt, knowledge of how and why these processes operate might cast a great light on spots now dark in the wide field of psychiatry.

But the point we are anxious to make is that we should not permit reaction against the seven and seventy jarring psychotherapeutic sects to drive us from the psychotherapeutic field to one in which, because we can see and touch the object of investigation, we fancy there is more certainty, more opportunity to find definitive answers. We do not see the field of psychotherapy as such a cloudy, obscure and turbulent place as do many of its critics. The various schools which have developed around psychoanalysis have much theoretical basis in common; and much of this common basis is well established theoretically and clinically. The quarrels about points of difference—some of them vital points, no doubt—have given an unwarranted impression to the uninitiated that a cellarfull of embittered tomcats are battling to the death in the dark. We think useful therapeutic endeavor and valuable research are being carried on despite—or perhaps because of the stimulation of —the caterwauling.

Group psychotherapy, begun experimentally and continued for empiric reasons, now has respectable theoretical bases and better than a respectable clinical record in patients benefited, or even cured. So also, with short psychotherapy, and such modalities as hypnotic treatment in private practice and institutions. We think a majority of practitioners today are convinced that they are giving greater help faster than a few decades ago.

The statistics of this sort of thing are difficult to obtain; for one thing, they would rest largely on highly individualistic clinical opinion; for another, the methods which reflect accurately hospital admissions and discharges are ill-adapted to cover the very different field of the psychotherapists in and out of institutions; perhaps new statistical techniques are needed, as well as a standard ized and co-ordinated method—if one is possible—for reporting, for comparative purposes, material which is now generally covered by notes of clinical impressions. We think, for the sake of Pasamanick and many others, more effort should be made to collect and present material of use to the epidemiologist.

But, we repeat that, susceptible to statistical treatment or not, the field of psychotherapy seems to have attracted the great majority of private psychiatric practitioners and a respectable number of institutional ones; and we feel that at least as great hope for the future lies here as anywhere. It is true that the psychotherapist is not dealing with anything detectable to the five physi-

cal senses, but only to the mind. But the mind, we may tell ourselves again, is as real as any bodily function or bodily organ. And we think we should not lose heart to investigate it through absorption in the quest for definitive answers. The well-trained investigator of the mind has every chance to come up with as satisfactory an answer as many an investigator of the body—for body or mind or space-time continuum, each has its quota of unanswered, and at present unanswerable, questions, questions for which not only definitive answers but any answers at all are at present unobtainable.

George Meredith was thinking of life, not of science:

> Ah, what a dusty answer gets the soul
> When hot for certainties in this our life!

But many a scientist has found his own dusty answer, if less final than Meredith's sepulchral one, at the end of his quest for scientific certainties. For in science there are few or no certainties; there are extreme probabilities, probabilities so strong that we may accept them for all practical purposes as certainties; we may refer to them in ordinary discourse as certainties; but they are not actual certainties. One's observations may be faulty or interpretation of what one observes dead wrong. And a futile search for Pasamanick's "definitive answers" or Blain's "definite proof" might well lead to the non-exploration of the most scientifically-profitable possibilities and probabilities. We have faith that psychiatry will not be dissuaded from exploration of every road open, by the lure of diverting research toward a promised but impossible end. We do not share what seem to be Pasamanick's pessimistic views about the worth of psychiatric inquiry in fields where "definitive answers" are not possible, nor Blain's worry because of belief in things without "definite proof." We do share Pasamanick's enthusiasm for more research in fields where answers to some ages-old enigmas may be possible. And we emphatically share Blain's belief that we shall proceed and make further advances.

The mind is inaccessible to the physical senses but is perfectly accessible to study by mind itself. As a natural phenomenon, it is a legitimate object of scientific study. We could make good use of knowledge of its linkage to, or integration with, the somatic phenomena which are accessible to the physical senses. But we have abundant evidence that we can comprehend much about the mind,

understand much about its ills, benefit it materially by direct therapeutic treatment—without waiting to learn everything that can be learned about mind-body relationships. We have set our course toward this end; we have made gratifying progress on it; and we intend to follow it unremittingly as long as the promise is held forth of better mental health and lessened human misery by our efforts.

BOOK REVIEWS

Sterioencephalotomy (Thalamotomy Plus Related Procedures) with Brain Atlas. A Description of Apparatus and Techniques. By E. A. SPIEGEL and H. T. WYCIS. 176 pages including index. Cloth. Grune & Stratton. New York. 1952. Price $8.00.

Spiegel and Wycis give a brief but detailed account of an apparatus and procedure used to produce localized subcortical brain lesions without the rather superfluous brain damage often produced by the usual methods employed in psychosurgery. Sterioencephalotomy, as presented here, appears to be rather too complicated to replace quickly prefrontal lobotomy of the more crude types, but seems to be ideally applicable to the destruction of brain nuclei or the interruption of brain pathways, in which instances an exactly located, sharply circumscribed lesion is highly desirable.

A noteworthy, if limited, steriotaxic atlas of the brain is also provided. Study of the atlas is facilitated by having the plates and their respective descriptions on facing pages, obviating the all too frequent necessity of turning pages back and forth in works of this sort.

Mental Prodigies. By FRED BARLOW. 256 pages including index. Cloth. Philosophical Library. New York. 1952. Price $4.75.

The author of this book is a long-time student of calculating prodigies and prodigies in general. It is devoted chiefly to brief reports of the seemingly incredible mental mathematical feats of the famous calculators of the last two and one-half centuries. As is well-known, some of them were *idiots savants* and others had little or virtually no education. The author is an experienced "mentalist" and his interest is particularly directed to the methods employed by the more spectacular calculators—when the calculators themselves knew them. The non-mathematical reader, however, may find it almost as difficult to employ some of the methods as to comprehend the results achieved. Barlow has included a chapter on famous memorizers and devoted another to mental magic, in which he discusses "a few of the many arithmetical effects which, after some practice, may be performed mentally by anyone of average intelligence." (This reviewer thinks many readers may find reason here to question their possession of "average intelligence.")

This book is a collection of facts and of notes on techniques. There is a minimum of speculation as to mental dynamics or organization. This may make the work all the better for the student of intellectual, as opposed to emotional, abnormalities He will not have to quarrel at the start with anybody's theories.

Psychiatry and Catholicism. By JAMES H. VANDERVELDT, O. F. M., Ph.D., and ROBERT P. ODENWALD, M. D., F. A. P. A. 422 pages. Cloth. McGraw-Hill. New York. 1952. Price $6.00.

This reviewer predicts that there will be many varied reviews of this book. The variations will depend upon which side of the "fence" the reviewer happens to be on.

In his foreword, Archbishop O'Boyle states, "From the time of the beginning of modern psychiatry to the present there have been problems concerning its relationship to Christianity. Many of the opinions voiced have been extreme. For some psychiatry has supplanted Christianity. Others find no room in the Christian fold for psychiatry, which they consider necessarily heathen. Neither of these extreme positions is true and both are harmful. Hence there has been a long-felt need of a book that would present a scientifically sane integration of psychiatry and Christianity. . . . This is a book that can be read with the assurance that the reliable findings of modern psychiatry are here fully and accurately presented with no prejudice to the teachings of Christianity. Since truth is one, the valid teachings of psychiatry cannot fail to harmonize with Christian ethics. By brilliantly using this norm as their flail in the rich harvest of psychiatric research, the authors have competently winnowed the wheat from the chaff."

One can sincerely say that one wishes that all this were true. Perhaps for Archbishop O'Boyle this is true, but for others there will appear a doubtful feeling, a feeling that perhaps instead of unifying psychiatry and religion, this effort has, for some, created greater confusion. On several different pages of the book it is implied that a psychiatrist is not qualified to treat emotional problems (except psychoses) because he does not know theology but that the priest is well qualified to treat such illnesses because he knows theology and can learn psychiatry. It is also implied that many psychiatrists are not qualified to treat emotional illnesses properly because they are atheists. One tends to question this, since practically no person in this world can honestly say that he has no God, whatever His name may be; nor can he say that he does not feel the presence of some supernatural being within and about him. No person should be denied the right to interpret his God or His emotional presence as he sees fit. He must not be coerced to interpret Him in a set manner. In this reviewer's opinion, it has never been the intention of the psychiatrist to persuade a patient to become atheistic, because all psychiatrists recognize the extreme value of religion in the treatment of the emotionally ill. The most for which the psychiatrist could be criticized would be that he is often broad-minded about religion.

If this were not so, how could he treat not only the Protestant, but the Catholic, the Jew, and others of varied faiths?

The authors make their greatest attack against Freud and his psychology. They grant concessions to Jung, Adler, Adolf Meyer, Thomas Moore, Eric Fromm, Karen Horney and others, but do not quite agree with anyone. The authors refer to their own "psychagogical method" of therapy, because "analysis by itself is not sufficient to effect a change and should be supplemented by the method of re-education. For this method the term 'psychagogie' has been coined; as the education of children is called pedagogy, so the education of the mind may be termed psychagogy." The authors really refer to a re-education in a religious and moral sense.

"The Catholic Church condemns any psychological or psychiatric theory or practice that clashes with the dictates of objective morality. . . . If there is a conflict between psychiatric and objective ethics, the former must cede the issue. Why? Because ethics deals with one's moral health, and psychiatry with one's bodily or mental health; the moral health is the more important of the two. . . . It is no secret at all that the knowledge of Catholic morality among psychiatrists is not always very profound; hence, it is understandable that many of them try to avoid answering such questions. Yet, the patients want an answer. Therefore, instead of simply brushing aside such questions, it would be more beneficial to the patient for the psychiatrist to refer him to a priest. Here, then we have an example of how a fruitful cooperation could be established between the pastor and the psychiatrist. . . . In practice, the problem will come down to this: is the psychiatrist justified in imposing his philosophy of life? . . . The psychiatrist who, consciously or unconsciously, would impose upon his patients his own philosophy of life would trespass the limits of his competence. . . . In simple words, if the therapist really deserves the name of psychiatrist, he must be able, through analysis and observation, to penetrate into the patient's personality and guide him according to the potencies, ideals, and aspirations that he discovers in his patient's psyche, regardless of whether they are hidden in the depth of his unconscious or are well above the level of consciousness. . . . If the psychotherapist is able to strengthen and steady the 'voice of conscience,' he is doing his client the best possible service. . . ."

In addition, the authors suggest that no non-Catholic psychiatrist is qualified to treat a mentally ill Catholic patient.

Apparently this book was written for the purpose of discussing psychiatry and Catholicism but nearly one-half of it describes the psychoses and other mental deviations in a way similar to many psychiatric textbooks. This latter part of the book, therefore, could have been left unwritten, although it is well done.

The Cardboard Giants. By PAUL HACKETT. 309 pages. Cloth. Putnam. New York. 1952. Price $3.50.

Paul Hackett was a cardboard giant; so were his fellows on the mental wards of a VA hospital. Cardboard giant is Paul's figure of speech for it, not his delusion. Paul had felt his world becoming unreal for a long time; he had served in the army and been diagnosed mentally ill; in post-war days, he came to feel that an evil Mind ruled the world, not a benevolent God, and the Mind's hatred was directed toward him and his family. So he went to a mental hospital where the Mind still pursued him.

The Cardboard Giants is his story of his life in, and emergence from, the hospital. The dust jacket misdescribes it as the "inspiring story of how psychiatry and religion worked together to return a man to mental health"—which is just what it isn't. The story is not uninspiring; and no doubt psychiatry and religion did work together—the author describes an understanding, helpful and tolerant psychiatrist and a gentle, helpful and understanding priest—but the tale of what they did for the patient's betterment, and of how they did it is not clearly told. One can only suppose that Paul himself attributes his recovery to their combined influence.

What this book is, is a patient's picture of his own mental state and of his fellow-patients and members of the staff of the hospital. It is a series of sketches, almost vignettes; it is clear; it seems objective; it is not fanatical; this reviewer detects no trace of the paranoid in it. It is a narrative which might almost have been told in the third person of a man's becoming progressively deranged, becoming hospitalized and becoming well again. It is also a series of clear and exceedingly interesting reports on a number of his fellow-patients.

The reviewer thinks this book is to be recommended in general to persons who could profit by better understanding of what the inside of a mental hospital is like and of what being a patient is like. It is splendid mental hygiene for this and other reasons; Paul's fellow-patients are believable, and not at all unlikable, suffering human beings; the doctors are human, if fallible; the hospital has its drawbacks as a vacation spot, but it is no collection of torture chambers; those who work in our hospitals will see in it how they appear to a patient—from poor to good contact. And the book is readable; even entertaining in spots; the story of Dr. Shepard, who wasn't a mental patient at all but who was transferred from a naval hospital to a VA mental ward by mistake, must be read to be believed. (His specialty is not one with which psychiatrists commonly have much contact; and his explanations and protestations were taken as part of his non-existent delusions.) Finally, the psychiatrist will want to read this book as an account—even if unusually lucid and well-polished—of a mental disorder by the patient. Such a document is always of value.

Pharmacology in Clinical Practice. By HARRY BECKMAN, M. D., director, department of pharmacology, Marquette University Schools of Medicine and Dentistry; consulting physician, Milwaukee County General Hospital and Columbia Hospital, Milwaukee, Wis. XX and 839 pages, including 152 figures, 48 tables, a compendium of drugs, bibliography and index. Cloth. Saunders. Philadelphia and London. 1952. Price $12.50.

Treatment in General Practice, known in its many editions as "the Beckman," is such a world-wide accepted standard textbook that it does not require any introduction or recommendation. But the present book by the distinguished author is a completely new, differently organized and originally conceived book that deserves special consideration. It will replace the former "Beckman" and will gain new friends and admirers. In its very individual and attractive style, it will guide the reader "in terms of specific diseases and symptoms and not of anatomical groupings of organs or chemical groupings of drugs" to the requirements of treatment.

It would be futile to review the general content of this encyclopedic textbook. But to give some of the flavor which it gives to the reader, it may be permitted in this place to cite the author's position on drug therapy in regard to psychiatry and neurology in his own words:

"At least half of your patients will have an emotionally determined or perpetuated disorder and should have psychiatric attention. But they cannot all be seen and carefully studied by psychiatrists, and so, if you are not a psychiatrist yourself you will have to cope with the situation as best you can. It would be fine if you could turn to these pages with confidence that you would learn of many specific or at least helpful drugs, but unfortunately that is not the case. Psychiatry and psychiatric concepts have begun to affect all medical branches. The psychiatrists are searching, too, among the other medical disciplines for aid and enlightenment regarding their own diagnoses and therapeutic approaches. It is too bad that pharmacology has offered so little as yet. The trouble is that the mechanisms of nervous actions are poorly understood and the application of scientific methods to the psychologic processes is extremely difficult.

"As for neurology, well, the poor neurologist cannot even earn a living in the practice of his specialty alone. He must function as a psychiatrist too, or do his neurology as a side line in another specialty. There are two reasons for this, and we in pharmacology are to blame for only one. In the first place, it is traditional that the neurologist must stop at diagnosis—someone else must treat his cases. In the second place, if he were to treat his own diagnosed maladies he would have little to work with. Pharmacology has simply not provided the drugs with which good 'specific' results can be obtained.

"Space limitations will permit me to deal pharmacologically with only a portion of the entities that are of neuropsychiatric nature. Most of the drugs mentioned will have had major presentation in the book and you are requested to consult the Index for information about them not supplied in the present chapter.

"Psychoneurosis: Here is our greatest pharmacologic failure in any field of medicine. A drug that would 'straighten out' the psychoneurotic individual would be a god-send to patient and doctor alike. But I do not know, perhaps the development of such a drug would not be so fine. It would at once cut down the necessity for so many doctors, and we all like to be doctors. There is no need for present worry, however, since we do not have the drug."

There is no other textbook of pharmacology which equals or surpasses this book as far as completeness, competent information, sound clinical approach and universality is concerned. It is a pathological physiology in a grand style. Many excellent illustrations, an up-to-date compendium of drugs and a carefully detailed index of 69 pages enhance its value.

The Transmission of Nerve Impulses at Neuroeffector Junctions and Peripheral Synapses. By ARTURO ROSENBLUETH, head of the department of physiology and pharmacology of the Instituto Nacional de Cardiologia de México. Cloth. XIV and 325 pages including preface, introduction, 720 references, author index and subject index; with 98 figures and 14 tables. Technology Press of Massachusetts Institute of Technology and John Wiley & Sons, Inc. New York. 1950. Price $6.00.

This new book by a distinguished author is the first comprehensive report on present-day knowledge, and on still "existing unsolved problems of the chemical transmissions at the junctions of motor nerves with striated muscles and at the synapses in autonomic ganglia." The theories of cholinergic and adrenergic stimulation find their epistomologic and experimental foundation. "It could not yet disclose if chemical transmission is the only mode of transmission. No generally accepted opinion can be given on the problem how the mediators, liberated by autonomic nerve impulses, act and how the inhibitory responses function."

The more complex and debatable problem of transmission in peripheral synapses is widely discussed in the second part of the book. The author stretches mainly his arguments of chemical transmission although he points out that many authorities believe in the prevalence of electric transmission at peripheral synapses.

This book with its careful bibliography and indices constitutes an indispensable text and reference book for the expert in cybernetics and neurophysiology.

The Spire. By GERALD WARNER BRACE. 380 pages. Cloth. Norton. New York. 1952. Price $3.50.

If the author of *The Spire* hasn't created a great novel he has at least offered his readers something to think about in devising a college professor who behaves both wisely and well in an atmosphere of embedded prejudice and suspicion.

The setting is a small New England college where the battle rages between Henry Gaunt's integrity and the traditional academic protocol of his fellow faculty members.

Perhaps New England literature has taught us to expect a frustrated spinster, a half-witted recluse, town gossips and fine minds gone to seed. They are all here. But it is to the credit of the author that he is able to make them real and extricate them from universal dilemmas with solutions that never descend to coincidence. No ultimate happiness is predicted, but one comes to feel that a wise man who can maintain his emotional balance may hope to make some impact on the bigotry and prejudice that beset us all.

Symposium on the Healthy Personality. Transactions of Special Meetings of Conference on Infancy and Childhood, June 8-9 and July 3-4, New York, 1950. Milton J. E. Senn, M. D., editor. 298 pages. Cloth. Macy Foundation. New York. 1950. Price $2.50.

This book is published on a cost basis so that investigators and workers in the field of child health and child welfare who were unable to attend the sessions can become acquainted with the interesting reports and stimulating discussions which took place at the meeting of the fact-finding committee of the Midcentury White House Conference on children and growth.

The subjects presented for discussion follow.

"Growth and Crisis of the Healthy Personality" was the subject of Erik H. Erikson who spoke of eight criteria of the healthy personality, commencing with trust in infancy and culminating in integrity at adulthood. The social radii of these criteria at different growth levels are taken up as are the crises which accompany each stage. The paper is primarily psychoanalytically oriented. However, the discussions presented by other members make the over-all picture more eclectic.

The second paper, "Constitutional and Parental Factors," was prepared by M. F. Ashley Montagu. Three factors are considered: "(1) What are the inherited genetic potentialities (the genotype) of the organism? (2) How are these influenced by the internal and external environmental factors during prenatal life? (3) What role does each of these factors play in influencing the subsequent physical and mental health of infant and child?" In considering these questions, the fetal "environment" is discussed at some length in terms of the transmission of emotion from the mother by the

neuro-humoral system; the effects of physical and nutritional stimuli; the results of maternal age; sensitization and dysfunctioning; as well as many other factors.

The third paper, "Toward a Social Psychology of Mental Health," by Marie Jahoda, was oriented around the import of community influences on the mental health of an individual. A worth-while and rounding-out discussion, complementing the two previous papers, revolved around the Kurt Lewin field theory that behavior is always a function both of personality and its environment.

The conclusions of these papers and their concurrent discussions are rich and manifold and cannot be summarized in a few words, but the reviewer highly recommends this book to all interested in human behavior, the personality and mental hygiene.

Psychotherapy of Psychosis. By GUSTAV BYCHOWSKI, M. D., assistant clinical professor of psychiatry, New York University College of Medicine. 328 pages including notes and references and index. Cloth. Grune & Stratton. New York. 1952. Price $5.75.

After reading this book one does not really know to whom it is addressed. It is a compilation of references and citations of the European schools of psychiatry presented in a rather unorganized manner, and it represents in its unsystematic verbosity an unsatisfactory review of an arbitrary eclecticist. It seems as if the author himself is struggling with clear terminology and the meaning of the no-doubt-industriously studied works of Kraepelin and Bleuler, Freud and Ferenczi, Husserl and Minkowski—to cite only a few. The author states that he "could show by way of analysis of the stream of thought that the waves of energy originating in the brain of schizophrenics have special characteristics." He further states, quoting from his own previous publications, that he "could show that the thought-products of schizophrenia are characterized by a weakening of a factor which we might call temporal order." But "after all, no matter what theory one holds regarding the initial and the essential disturbance in schizophrenia, still nobody could deny that schizophrenics think, speak, perceive and write with their brains like anybody else." (Compare Franz Alexander: "His [the psychotic's] thought-processes and feelings are so different from those of healthy persons that common sense cannot grasp them.") It is not doubted that the intention of this publication is a worthy one. Each of the 34 chapters may be an industriously prepared lecture in which many statements may be made which sound differently when presented under the stimulating atmosphere of the give and take of an interested student audience. But to write a textbook is a different story. It requires planning, organization, systematization and clarification on a high and matured level. This well-meant book offers none of them.

Cybernetics. Circular Causal and Feedback Mechanisms in Biological and Social Systems. Transactions of the Eighth Conference, March 15-16, 1951, New York, N. Y. Heinz von Foerster, department of electrical engineering, University of Illinois, editor. Margaret Mead, American Museum of Natural History, and Hans Lukas Teuber, department of neurology, New York University College of Medicine, assistant editors. XX and 240 pages, including Josiah Macy, Jr. Foundation Conference Program (by Frank Fremont-Smith, M. D., medical director), a note by the editors, Appendix I, the nomenclature of information theory by Donald M. MacKay, King's College, University of London; and Appendix II, references. Cloth. Macy Foundation. New York. 1952. Price $4.00.

This book cannot be reviewed because "this is," in the words of the editors, "not a book in the usual sense, not the well rounded transcript of a symposium."

But no one who is himself in the front line of scientific research, no one who wants, at least, to keep his finger on the pulse of the indefatigable heart of scientific progress, and no one whose mind is receptive enough to feel the thrill of being present at the birth and development of new spheres of knowledge should miss studying this volume thoroughly. Cybernetics —so-called by Norbert Wiener, the great mathematician of M. I. T.—is the science of transmission and communication; and this present document is "an account which attempts to capture a fragment of the group interchange in all its evanescence, because it represents to us one of the few concerted efforts at interdisciplinary communication."

The reading of this volume gives an unusual stimulation because of the mainly extemporaneously-presented subjects and the unprepared discussions on the highest level. It brings the reader into the presence of creative research. Topics discussed include: communication patterns in problem-solving groups; meaning of language as communication between men; hypnosis as communication between sane and insane; communication between animals; presentation of a maze-solving machine; in search of basic symbols. But these cannot show the extent and the universality of the problems stressed. But they may—the reviewer hopes—stimulate the reader of these lines to become interested and to read these transactions.

The Superego. By Edmund Bergler, M. D. 367 pages. Cloth. Grune & Stratton. New York. 1952. Price $6.75.

The Superego is a thought-stimulating, and emotion-provoking, study of the unconscious conscience as the key to the theory and therapy of neurosis. If the reader can overcome the tricks his own super-ego will play on him as he reads this exposition, he will have a better understanding of so-called normal as well as of neurotic behavior problems.

While Bergler's previous books have been written for both the general practitioner and the specialist, *The Superego* seems to have been written with the analyst primarily in mind, although it, too, is written with the same simplicity of style and phrasecology, and with the good sense of humor, typical of Bergler's approach to the results of man's attempt at a "defense against the defense."

The Basic Neurosis and *The Battle of the Conscience* set forth Bergler's theories, with supporting clinical evidence derived from 25 years of psychoanalytic psychiatric experience. *Money and Emotional Conflicts* and *Neurotic Counterfeit Sex* described in detail some of the many disguises the basic neurosis—psychic masochism based on oral regression—assumes. In this latest contribution, the blame is placed on the super-ego as the instigator of these problems. Man uses 50 per cent of his productive energy in his efforts to defend himself against his internal conflicts, Bergler states.

The foreword provides an excellent background of Freud's thoughts and writings in the last years of his life on the role of the unconscious conscience. The first two chapters give details of the structure of the superego. This is followed by the psychic microscopy of 50 human reactions, selected at random: Ordinary daily occurrences and attitudes are explored, such as cynicism, pessimism and optimism; the matter of being a wit; patience and impatience; silence and hypertalkativeness; over-drinking and chain-smoking; and reactions on waking up in the morning. The chapter on "Dreams and Inner Conscience" delineates why Bergler and Dr. Ludwig Jekels in 1933 came to the conviction that the formulation ". . . every dream represents an unconscious wish-fulfillment" should be enlarged to ". . . every dream represents an unconscious wish-fulfillment and a defense against a reproach of the superego."

"Are Parents or Inner Conscience to Blame for the Neuroses of Children" is a chapter which will be read with relief, tinged with despair, by those who try in the middle of the twentieth century to do what is "right" for their children.

Bergler concludes ". . . every human being—in quantitatively different degree—becomes 'addicted' to psychic masochism . . . But knowledge does help—somewhat . . . (for it) also is the potential power to accept reality without much ado and without whimpering of the 'I feel sorry for myself' variety."

Anstaltskinder (Nursery-Children). By D. BURLINGHAM and A. FREUD. 138 pages. Cloth. Imago Publishing Co. London. 1950. Price 8/-.

The booklet was first published in English in 1943; this German translation is now available. The topic is the case for and against residential nurseries. The material is interesting; the conclusions are marred by lack of precise differentiation between pre-Oedipal and Oedipal mother, and by not stressing the importance of masochistic components.

The Thyroid. By THOMAS HODGE MCGAVACK, B. A., M. D., F. A. C. P., professor of clinical medicine, New York Medical College; director of New York Medical College, Metropolitan Hospital Research Unit. With a Section on Surgery by James Winfield, B. A., M. D., F. A. C. S., professor and director of surgery, New York Medical College, and Walter L. Mersheimer, B. S., M. D., F. A. C. S., associate professor of surgery, New York Medical College; and a section on history by Dorothy B. Spear, Ph.B., librarian, and Thomas Hodge McGavack. Cloth. 646 pages including 22 tables, 72 figures, bibliography and index. Mosby. St. Louis. 1951. Price $13.50.

Very few organs of the body have stimulated more research work than the thyroid gland. Superseded only by the antepituitary, "the conductor of the symphony of the endocrine glands," the thyroid gland represents about the position of the first violins. Every year, there appears in the literature an overwhelming amount of detailed individual material—to keep track of which is nearly impossible for the non-specialist in the field. Dr. McGavack and his co-workers have undertaken the tremendous job of giving a comprehensive review of the present state of our knowledge of the physiology and pathology of the thyroid in a single-volume monograph. Very few authors are as competent for this task as Dr. McGavack, who himself has contributed so much to present knowledge.

The book is organized in four sections: Section I on history; Section II on anatomical, chemical and physiological considerations; Section III, the largest part, on morbid states; and Section IV on surgical considerations. The authors have done a great service in offering this monograph. Its very well-written content is supplemented by good illustrations, many tables, an international bibliography and a good, clear index. This book can be recommended highly as a text and for reference.

The Treatment of Injuries to the Nervous System. By DONALD MUNRO, M. D. 284 pages including index. Cloth. Saunders. Philadelphia. 1952.

Here is an excellent, concise guide to the do's and don'ts of treating nervous system injuries of all kinds. Its numerous tables make the location of diagnostic and therapeutic measures both convenient and rapid. Emergency and definitive procedures are given equal, and thus correct, emphasis, and the important problem of rehabilitation of paralyzed patients is not overlooked. Occasionally, practicality suffers for the sake of technical and theoretical accuracy. Nevertheless, this book should prove valuable to less specialized practitioners, who, from time to time, must assume responsibility for persons suffering from traumatic lesions of the nervous system.

The Meaning and Practice of Psychotherapy. By V. E. FISHER, Ph.D., psychologist and psychotherapist. XV and 411 pages including preface, introduction, selected readings, glossary and index. Cloth. Macmillan. New York. 1950. Price $5.00.

This book of 411 pages on the "meaning and practice of psychotherapy" starts with 43 pages entitled "a general orientation concerning approach and procedure." This section, Part I of the book, appears rather inadequate for many reasons and therefore misleading. Three hundred and fifty more pages contain records of treatments. This latter material is subdivided in three parts: Part II, some psychotic and closely related disorders; Part III, psychoneurotic reactions; Part IV, some maladjustive psychosocial tendencies and reactions. This classification and the terminology used show a rather incongruous systematization, considering the title and possible intention of the book. The chapters containing case records differ in their quality and acceptability.

It is not quite clear into what gap this book fits. At the best, it may serve to arouse the critical faculties of a well-organized and systematically-trained psychologist or psychiatrist. As a textbook, it is inadequate; as an introduction for the student, it appears too unsystematical.

Statement on Race. New Revised Edition. By ASHLEY MONTAGU. 182 pages including index. Cloth. Schuman. New York. 1951. Price $2.75.

This is a second edition of the famous *Statement on Race* drawn up for UNESCO by a group of the world's leading social scientists. This edition includes, for the first time, a statement on the nature of race and race differences by a group of physical anthropologists. The group drafting the original statement was made up largely of social scientists; there were naturally some criticisms; and the physical anthropologists now present their own point of view, stressing the biological aspects. So far as the general reader is concerned, the statement of the physical anthropologists is in substantial agreement on every important point with the original statement and should reinforce the authority of the latter. Social scientists in general will agree with the principal points of both.

This volume is an important weapon for the armamentarium of any social scientist, including the psychiatrist, who may be faced with a problem of prejudice involving a racial question. It is an excellent basic text for elementary instruction and a fine basic statement for general reading. As presented here, the UNESCO statement is first given in full; then it is reprinted by paragraphs, with Montagu's discussion of each paragraph. The fighter for the cause of truth and tolerance can do no better than wish this volume the widest possible circulation.

Die Execution des Typus und andere kulturpsychopathologische Phaenomene. (The Execution of the Type and Other Psychopathologic Phenomena of Culture.) By Professor Dr. W. Wagner. 135 pages. Thieme. Stuttgart. 1951. Price DM 15, 60.

The foreword informs us that the problems of psychopathology of culture are approached from the psychiatric viewpoint. The text proves that the promise is so little kept that one has to reread the foreword to ascertain that a psychiatric promise was made in the first place. The book is the worst example of circumlocution this reviewer has encountered in a long time. What the author wishes to convey remains a mystery. As far as one can make head or tail of his words, he seems to reject typology, and excells in highly ambiguous statements, not even the descriptive psychiatric viewpoint is represented; it seems superfluous to state that unconscious mechanisms are not mentioned at all. At one point, the author exclaims: "Our position as cultural psychopathologists is that of despair (*ist zum Verzweifeln*). We never learn enough of human nature." Quite true: By avoiding unconscious mechanisms, ignorance of man's nature is perpetuated.

It Takes All Kinds. By Maurice Zolotow. 304 pages. Cloth. Random House. New York. 1952. Price $3.00.

Maurice Zolotow likes to write about people whom he considers eccentrics. The present volume is a collection of sketches of 11 contemporaries, some of whom are of psychological or psychiatric interest. He devotes 60 pages to Dunninger, whose claim to extrasensory powers of perception has been widely publicized. He leaves the reader to form his own conclusions, of which a reasonable one might be that Dunninger does have some of the faculties he claims but that he lays claim to much else that he does not possess. This is a phenomenon not at all unknown in psychical research circles.

The other characters all have their points of interest. The author makes, however, what may be considered a regrettable attempt to trace their eccentricities to childhood circumstances. One suspects that he may have hit upon truth in some instances or at least upon partial truth, but the evidence is not convincing. This reviewer thought that Zolotow was writing in terms of Adlerian psychology until he came to the final chapter, "Acknowledgment," in which the author says, "A great deal of thinking that has shaped my analysis of the persons in this book reflects the ideas of the late Harry Stack Sullivan." The reflection is a surface one, and the reader might do well not to take the psychodynamics seriously; but *It Takes All Kinds* is, for pure entertainment values, well worth reading

Psychiatry and Medicine. An Introduction to Personalized Medicine. By LESLIE A. OSBORN, M. D. 490 pages. Cloth. McGraw-Hill. New York. 1952. Price $7.50.

The reviewer of this book was well acquainted with the author when the latter was a general practitioner of medicine. In those days, Dr. Osborn seemed particularly interested in psychiatry and was in attendance at all psychiatric meetings. He was always a good speaker, and his discussions were always very well expressed. He continues to show such abilities in what, the reviewer believes, is his first book. As a whole, the book is extremely good, well organized and scholarly. It is apparently based upon lectures which the author gave during his teaching of medical students, psychology students, social workers and nurses. It is a book which all teachers of such groups can use in helping them to prepare their own lectures.

The reviewer gains the impression that, in this book, Dr. Osborn is reviewing and recording a method of learning the basic principles of psychiatry as he got to know them when his interests changed from general medicine to psychiatry. Furthermore, as stated on the book jacket, the book "... presents one physician's integrated concept rather than presenting a number of points of view sufficiently at variance to confuse the student who is trying to grasp the subject as a whole."

The Valiant Coward. By Y. ESTHER LIVINGSTON. 310 pages. Cloth. Dorrance & Co. Philadelphia. 1950. Price $2.50.

Here is a badly written novel with an interesting plot: A young boy witnesses the mistreatment of a horse by an elderly neighbor, and throws a stone in his fury; the man collapses and dies; the boy considers himself a murderer. In reality, the death was caused by a kick of the horse; the facts become known to the stone-thrower many years later. In the meantime, his whole life becomes one great penance. De Maupassant once wrote a story of a necklace where a similar theme is ironically, and not tragically, elaborated. Otherwise, there is little to recommend the book; the psychological implications are omitted, with exception of the guilt-theme.

He, the Father. By FRANK MLAKAR. 313 pages. Cloth. Harper. New York. 1950. Price $3.00.

This is a novel about Slovenian immigrants in this country, centering around a masochistic couple. The author seems to have some superficial knowledge of the Oedipus complex, and he makes the most of it. As he is a gifted writer, a good deal of pre-Oedipal material is included, though he obviously does not know how to handle it. Despite some confusion in the book, it is worth perusing.

Progress in Neurology and Psychiatry. An Annual Review. Volume VII. E. A. Spiegel, M. D., editor. 592 pages. Cloth. Grune & Stratton. New York. 1952. Price $10.00.

This annual review continues to be of high quality. Those who have previous volumes will want this one, too, and those who have not previously had the review and need a reference book in these subjects should add this one to their libraries. The reviews are very brief but they cover enough to inform the reader about the articles summarized so that if he wants more information the numerous references can tell him where to find it.

This year, there are the usual sections on basic sciences, neurology, neurosurgery and psychiatry, but new chapters on pediatric neurology, on genetics, on the neurosyphilises and on criminal psychiatry have been added.

The Contributions of Harry Stack Sullivan. A Symposium on Interpersonal Theory in Psychiatry and Social Science. Patrick Mullahy, editor. 228 pages. Cloth. Hermitage. New York. 1952. Price $3.50.

In some psychiatrists' minds, there is gradually developing a trend toward a psychiatry that is more understandable to the patient. The psychiatrist must know the dynamics and mechanics by which mental illnesses arise but explaining the mechanics to a mentally-ill person does not often produce results therapeutically. It is because of this psychiatric viewpoint that this book is of importance at present. It is a review of the interpersonal psychiatry of Dr. Sullivan by men who knew and understood him. It gives a clearer picture to those who have failed to understand just what Dr. Sullivan meant. It brings to light many of his unpublished ideas. It reviews all of his ideas relative to theory, to clinical application and to sociological values.

The Clinically Important Reflexes. By Dr. med. Friedrich Wilhelm Bronisch, instructor, research assistant, Psychiatric and Neurologic Clinic, University of Heidelberg. Revised and enlarged by Clemens E. Benda, M. D. 88 pages including bibliography, index and 49 large didactic illustrations. Cloth. First American edition. Grune & Straton. New York. 1952. Price $4.75.

Excellent service is done by Dr. Clemens E. Benda in offering an English translation of Bronisch's book on clinically important reflexes. This well-written manual, enlarged and revised, is a very useful and comprehensive guide through the theory and practice of the neurological examination, limited to the application of the accepted and important reflexes. The clear presentation enhanced by excellent schematic drawings can become a very useful pocket manual for the general practitioner as well as for the neuropsychiatric student and intern.

Man and His Gods. By HOMER W. SMITH. 501 pages including index. Cloth. Little, Brown. Boston. 1952. Price $5.00.

Albert Einstein, in a brief foreword to *Man and His Gods,* calls the book "a broadly conceived attempt to portray man's fear-induced animistic and mystic ideas." The reader will find it a reasonably good elementary text of comparative religion, containing a good deal of valuable material. The orthodox member, of whatever sect, will not like it. Professor Smith's point of view, as he states in the epilogue, is: "As a fallen angel, man would be ludicrous. As an intelligent animal he has reason to be proud. . . ." Man, of all creatures, says the author, "alone can see himself and his world in width and depth. He alone can choose out of his vision of the present and the past his future course."

Aside from the author's point of view, the text part of his book would be vastly improved by references and bibliography. One presumes they were omitted in an effort to compress, but the author devotes more than 40 pages to "the story of this book"—and of himself. He had difficulties in finding a publisher, and the subject is of some interest, but the reviewer would have preferred a bibliography nevertheless. The acknowledgments in the text and the explanatory acknowledgments in this final chapter are not arranged for easy reference or as ready guides for further reading. The volume therefore lacks authority but may be recommended as a general guide to a difficult subject to persons who will not take offense at some of the author's downright personal opinions.

This Is Your World. By H. A. WILMER. 152 pages. Cloth. Thomas. Springfield, Ill. 1952. Price $5.50.

Dr. Wilmer's book attempts to convey to professional workers some of the emotional problems encountered in chronically ill tubercular patients. It is a guide for group therapy; it contains a long poem—a ballad—and 16 dialogues concerning parent-child relationships. The intentions are good, the drawings of the author interesting; what is missing is one of the decisive emotional conflicts: the masochistic misuse of (and contribution to) the illness.

Zero. By ROBERT PAYNE. 262 pages. Cloth. John Day Co. New York. 1950. Price $3.50.

Zero is a valuable and extensive, descriptive history of nihilistic terrorism, starting with Nechayev's *The Revolutionary Catechism,* tracing the influence of the theory of total destruction to Nechayev's pupils, Hitler and Lenin. The compilation of material is impressive; the weak point of the book is lack of a psychological explanation of the nihilist's mental aberration.

The Infirmities of Genius. By Dr. W. R. Bett. 192 pages including index. Cloth. Philosophical Library. New York. 1952. Price $4.75.

The Infirmities of Genius is a series of sketches of 15 of the literary great about whom the author remarks that "the medical diagnosis of a man long dead is always difficult." He notes that he is nevertheless presenting his essays to the general public despite their speculative content because he believes that "an intimate and sympathetic knowledge of an author's medical or psychiatric case-history will enable the reader to appreciate or enjoy his works all the more." The aim is to be applauded; and the result is a volume which may be of some interest to persons—if such there are—who are not aware that many of the great had mental infirmities. It will not appeal, however, to either the literarily or medically sophisticated.

Lord Byron, for instance, is discussed as an instance of "lameness and genius." But Byron's psychopathic behavior is treated most sketchily. There is no discussion whatever of Byron's reputed incest with his half-sister; and his relationship with Claire Clairmont is mentioned without a note that she had an illegitimate child by him. The sometimes prudish Encyclopaedia Britannica, which dismisses (as of 1947) the *cause célèbre* of Oscar Wilde by noting that he was sentenced "under the Criminal Law Amendment Act," is much more informative about Byron's psychopathology than is Dr. Bett. Similarly, Walt Whitman is described in Bett's chapter heading as an "invert," but the discussion is vague, oblique and inconclusive. One can deduce the author's opinion only from the chapter heading.

Dr Bett has done stimulating and informative writing elsewhere on the subject. In an introductory note to the present volume, he states he has rewritten for it some articles, previously published in a scientific journal, with their "medical 'jargon' discarded." It is both reasonable and charitable to suppose that considerable bowdlerizing was done at the same time, a procedure which—advisable or not for readers in Great Britain where the book was printed—has damaged the work irreparably for scientific, literary or general reading in America.

Attaining Manhood. A Doctor Talks to Boys About Sex.

Attaining Womanhood. A Doctor Talks to Girls About Sex. By George W. Corner, M. D. 92 and 107 pages respectively. Cloth. Second editions. Harper. New York. 1952. Price $1.50 each.

These companion books should be on the shelves of every public library. The books are well organized, clear, straightforward, non-technical in most respects and with accurate illustrations. Youngsters of today are asking for and are entitled to frank advice. Too many parents fail to extricate sex from an atmosphere of mystery and badness. These books describe not only the biology of sex but also the psychology of sex.

Speech Training. By A. Musgrave Horner. 176 pages. Cloth. Philosophical Library. New York. 1952. Price $3.75.

The author points out that since all speech is acquired by imitation, it is, therefore, unwise to be dogmatic about the best way to teach clear and intelligible speaking. He has provided here what he describes as "a collection of information indispensible to the serious student," and he would seem to imply that he may not know all that is to be known on the subject —a reasonable outlook, for in the matter of breathing, alone, there are many schools of thought. The author's views are well-reasoned and appear sound psychologically, but there is a dry, as well as physiological matter-of-fact presentation which will not appeal to many modern teachers. It should be mentioned that the book has excellent diagrams which many should find useful.

Understanding Heredity. By Richard B. Goldschmidt. 228 pages including index. Cloth. John Wiley & Sons, Inc. New York. 1952. Price $3.75.

The author of this book expresses the belief that generally available books on genetics are too advanced and contain too much specialized material "for a large number of students who do not intend to specialize in biology." This book is intended for such students. It is elementary. The specialist will find condensations, generalizations and omissions. But this reviewer thinks it is admirably suited for its stated purpose. In the discussion of human genetics there are pleasing reticence and conservatism where the inheritance of mental characteristics is concerned. This book is adapted for such purposes as a school of nursing text or for reading for information by lay persons in general. There is an adequate glossary and an index sufficient for general reference purposes.

Medical Biographies. By Philip Marshall Dale, M. D. 259 pages. Cloth. University of Oklahoma Press. Norman. 1952. Price $4.00.

Dr. Dale presents brief notes on the medical histories of 33 famous persons, ranging from Gautama Buddha to Grover Cleveland. It is a useful summary of material taken from generally accepted sources, and is a book which is both interesting and likely to be handy for reference. Dale's interest appears to be primarily in physical medicine and surgery, but he gives adequate and intelligent consideration to the psychiatric disorders. His discussion of Edgar Allan Poe is brief but sufficient, and Dale is of the opinion that Poe's manic-depression both preceded and underlay his alcoholism. He leaves the question of Walt Whitman's homosexuality open but discusses it adequately. There are 15 pages of references and sources for persons wishing to pursue the investigation of any individual further.

The Birth of a Child. Obstetric Procedures in Normal Childbirth for Those Who Attend Women in Labor. By GRANTLY DICK READ. 111 pages, 21 illustrations. Cloth. The Vanguard Press. New York. 1950. Price $1.50.

Introduction to Motherhood. By GRANTLY DICK READ. 99 pages, 23 diagrams. Cloth. Harper. New York. 1950. Price $1.75.

The author of the well-known *Childbirth Without Fear* stresses in both of these volumes the theory that the pain of childbirth is due to the factors of fear and tension. He makes definite and concrete suggestions as to how to counteract these unhealthy emotions through education for motherhood, by knowing just what is going to happen during childbirth, and, in addition to that, through training prospective mothers to have the ability to relax their bodies at will. *The Birth of a Child* contains in an appendix letters from women who describe the physical and emotional benefits they have derived from "natural childbirth." The books are simple in language and written with missionary fervor. Many a reader, lay as well as professional, critic or follower of Dr. Read's, will gather many interesting suggestions through reading these recent publications.

Living in Balance. By FRANK S. CAPRIO, M. D. 246 pages. Cloth Arundel Press. Washington, D. C. 1951. Price $3.75.

This book was apparently written for the lay reader. It is easy reading, employs non-technical terms and expresses an easy and hopeful philosophy which, to the psychotherapist, sounds a bit too easy and simple. It sets forth many bits of advice in a "1-2-3" manner; but to tell a person to stop worrying is too easy a prescription, and the patient cannot often get well on this type of medicine. Dr. Caprio's ideas are good, however, and what he really tells the reader in his book is summarized in the first paragraph, as follows: "Life is a continuous conflict and whether we remain normal or become neurotic, or even psychotic (insane), depends upon our ability to meet new situations, pleasant or unpleasant—how well we control our emotions and sublimate our unhealthy desires into good deeds, without harm to others and without detriment to that personality which is oneself."

Many Are Called. By EDWARD NEWHOUSE. 384 pages. Cloth. Sloane. New York. 1951. Price $3.75.

These short stories revolve around people disgusted with, and sometimes trapped by, the pettiness and insincerity of the world around them. The author has a strong ability to provide powerful situations from the commonplace, without having recourse to the unusual in a search for material. This reviewer failed to find one story in all of the 42 that he did not enjoy, to a greater or lesser degree; a compliment he could rarely give.

Social Psychology. By SOLOMON E. ASCH. 646 pages. Cloth. Prentice-Hall. New York. 1952. Price $5.50.

The purpose of this book is, as the author states, "... to bring some problems into sharper view, to seek theoretical and empirical clarification at some points, and where possible to sweep aside misconceptions." Thus, it has not been the author's intention to write a system of social psychology. "The time does not seem ripe for such an undertaking." Dr. Asch tells the reader to "be advised that psychology ... does not have ready answers to our most urgent questions." He (the reader) needs to make his peace with the fact that he is approaching a pioneer field in its early stages and that the account he is invited to follow will not contain a recital of delusive achievements as much as an exploration of problems and first groping efforts at clarification.

The point of view is that of Gestalt theory and the author presents experimental findings based on his own researches. The book consists of five parts. Part I is an introductory chapter on the "Doctrines of Man." Part II consists of two chapters on "Organization in Psychological Events." Part III, entitled "Human Interaction," includes emotional interaction and a study of group interaction. Part IV deals with social needs and includes chapters on "The Ego," "Social Interest," "Rules and Values," and "The Fact of Culture and the Problem of Relativism." Part V is on "Effects of Group Conditions on Judgments and Attitudes." Here the author discusses the areas of suggestion, opinions and attitudes, sentiments and attitudes, and concludes with a discussion on propaganda.

The Menopause. By LENA LEVINE, M. D., and BEKA DOHERTY. 198 pages. Cloth. Random House. New York. 1952. Price $2.50.

It would be difficult to find a better combination to write such a book than the co-authors, a woman psychiatrist and a woman journalist. One produces facts and the other gives the style. As a result, this book is especially well written and is the best one on the subject, in this reviewer's opinion, that has been written. It should be in every public library and should be found in every doctor's waiting room.

The book asks and answers five important questions: "What is the menopause? What is a woman? What really happens? What can be done? What of the future?" The authors clearly and frankly describe the physiological and psychological manifestations of the menopause and encourage the excommunication of the hopeless and fearful attitude expressed by so many women. In answering the question, "What is a woman?" the authors insist upon the emancipation of woman from her sexual taboos and obligations. "... The menopause is simply an event marking a change—the climax of the longest phase of a woman's life—not a tragic affliction nor a hopelessly desexing mark of age."

"What really happens?" By means of brief case records, the authors demonstrate that tradition, odd notions, hormonal deficiencies, and emotional instabilities created by temperamental and personality defects bring about severe menopausal symptoms. The authors frequently repeat that the physiological menopausal symptoms are only a small part of the total picture.

"What can be done?" The authors suggest not only a medical or physiological re-evaluation and treatment but also a re-evaluation of the woman's psychological self. They suggest, too, that there must be a re-evaluation of the family unit. "One main point to bear in mind is that all this applies to men as well as women. It is no longer possible to educate women about themselves without involving men, too, if only because men and women must live together as human beings all their lives. And particularly because men also go through a climacteric phase, preparation for them is as essential as it is for the woman. . . ."

"What of the future?" The authors express their belief that modern progressive thinking and fact-finding will alleviate many menopausal problems. "It is also important that today's young women have just about given up the age-old habit of being ashamed of themselves as women. The contemporary young woman or young girl is trained to think about herself in the most realistic fashion women have ever known. . . ."

Alimony: The American Tragedy. By Dr. CHARLES WILNER. 329 pages including bibliography. Cloth. Vantage Press, Inc. New York. 1952. Price $3.50.

Dr. Wilner has crusaded against what he considers abuses in our alimony laws for nearly 30 years. The dust jacket states that he is not a misogynist: "He is happily married and the father of a grown son." But he lashes out at "our American matriarchy," refers repeatedly to the "weaker state" of women, and expresses bitterness for page after page over "feminism rampant." In another context, he notes that it is imperative that all political parties uphold "race purity." He expresses extreme opposition to intermarriage, with particular reference to Negroes. He states that he is "absolutely free from any kind of prejudice," but is "as much against race mixture as are the intelligent people of all races and climes." And he blames "feminism" for the extent of modern miscegenation.

This book covers a field full of abuses, in which a competent compilation of material should be of use to almost any social scientist. Dr. Wilner's effort at a compilation is unfortunately shrouded in Victorian sentimentality (or maybe in the Teutonic ideal of *Kirche, Küche und Kinder*), clouded by emotion, and obscured by a sweeping disregard of modern findings in social science—even those of recognized authorities whom he cites in his bibliography.

Frontiers in Medicine. The March of Medicine, 1950. XII and 150 pages, with Foreword by Harold Brown Keyes, M. D. (representing the Committee on Lectures to the Laity). Introduction by Iago Galdston, M. D. (as executive secretary), references and index. Cloth. Columbia University Press. New York. 1951. Price $2.50.

"The Lectures of the New York Academy of Medicine to the Laity" are an indispensable institution of the cultural life of this country and do not require an introduction. As Dr. Galdston points out, the "consistent aim of the Academy to advance understanding *in* the spread of knowledge," will be furthered by these lectures. Distinguished scientists, Franz Alexander, David Seegal, Laurence H. Snyder, John H. Gibbon, Jr., Selman A. Waksman, and Thomas M. Rivers, review the progress and extension, the overlapping and restrictions of their special fields. Not only the laity will profit by studying the "frontiers in psychiatry," "the biological aspects of antibiotics" or "the concepts and methods of medical research" (to mention only three of the six lectures), the student and the physician in practice will be equally stimulated and informed about the gains and consolidated areas of medical research work.

In this place Dr. Alexander's lecture must be particularly mentioned, a lecture which he limits to the sociological implications of modern psychiatry. It is interesting to follow him through the history of human relationships with its sociologic and psychologic aspects through problems of psychologic warfare and of group dynamics to the conception of the need for a valid science of sociodynamics which in the future may contribute to "assuring a more reasonable relationship between nations."

He Hanged Them High. By Homer Croy. 278 pages including index. Cloth. Duell, Sloan and Pearce. New York. 1952. Price $4.00.

He Hanged Them High is a pedestrian biography of a fascinating figure, Judge Isaac C. Parker, of the United States District Court of Western Arkansas in the days of America's Wild West. His jurisdiction lasted 20 years and covered a wide, primitive and lawless territory—that is, lawless until Parker got there. Parker sentenced so many men to death that one of Croy's chapter headings reads "Judge Parker Hangs Only Five Men." Some of the most notorious figures of a vanished day appeared in Parker's court—and more in his personal story. Croy tells us that Parker was a zealot; and he seems to have been convinced indeed that he was an arm of the Lord. He sentenced with vast indignation, but there is evidence that he was not happy on the days of executions.

A study of how Parker came to be the avenger of the law and of what motivated him would be a fascinating document. Mr. Croy's report unfortunately does not provide even a skeleton upon which to drape such a tale.

Physician to the World. The Life of General William C. Gorgas. By JOHN M. GIBSON. IX and 315 pages including prologue, epilogue, bibliography, index and six illustrations. Cloth. Duke University Press. Durham, N. C. 1950. Price $4.50.

The life history of Dr. William C. Gorgas, surgeon general of the United States Army during World War I, is a reflection of a cultural epoch of great significance. It is also the story of the unending idealism out of which real physicians are molded, it is the never-aging tale of the searching minds of men who remain young in their urge to know and to penetrate the secrets of nature—a book of stimulation and optimism.

That this, at the same time, represents a great era for the United States Army Medical Corps and its policy is a matter of great credit to the medical corps. Dr. Gorgas' devotion to his work, his zealous preparedness for self-sacrifice in the face of nearly unsurmountable odds, his exemplary courage, coupled with sincere modesty, rank him near the greatest of our profession.

This honest, inspiring book will be appreciated by all scientifically-minded physicians who have a flair for the cultural history of medicine. An excellent bibliography, the illustrations, and the index contribute to the book's value.

Opportunities in Nursing. By EDITH PATTON LEWIS, R. N. vi and 128 pages. Paper. Vocational Guidance Manuals. New York. 1952. Price $1.00.

Opportunities in Social Work. By JOSEPH P. ANDERSON. vi and 112 pages. Paper. Vocational Guidance Manuals. New York. 1952. Price $1.00.

These manuals contain a great deal of helpful information. Their coverage is not exhaustive, but they can be utilized as easily available "question answerers" by libraries, high schools, and colleges. The main fault this reviewer finds is that only too often, they sound, when discussing a career, like the local chamber of commerce drumming up business.

Specific Dyslexia. By BERTIL HALLGREN. 287 pages. Acta Psychiatrica et Neurologica, Supplementum 65. Ejnar Munksgaard. Copenhagen. 1950. Price not stated.

This study of "congenital word blindness" was conducted during the years 1947 to 1950 at the psychiatric clinic of Karolinska Institute in Stockholm. Two hundred and seventy-six cases were studied phenomenologically and statistically. The specialized work includes the stressing of "nervous disorders," without clarifying the unconscious tributaries.

CONTRIBUTORS TO THIS ISSUE

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Following discharge from the public health service with the rank of surgeon (major) he returned to psychoanalytic practice, and in 1947 was appointed to the faculty of the comprehensive course in psychoanalysis, postgraduate division, department of psychiatry, New York Medical College-Flower and Fifth Avenue Hospitals, and in this capacity has continued as a teaching and training psychoanalyst. He is on the staff of Flower and Fifth Avenue Hospitals, and is a member of the American Psychiatric Association and of the Society of Medical Psychoanalysts.

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ELI LOCKERT BEMIS, JR. Mr. Bemis is a research analyst who prepared the basic data for the study of hospitalization, readmissions and stability of diagnoses in Veterans Administration hospitals—of which he is co-author—which appears in this issue of THE PSYCHIATRIC QUARTERLY. He is the author of administrative manuals for public utilities and government agencies and was on the staff of the department of medicine and surgery of the Veterans Administration at the time this study was made. He describes himself as an "occasional student of mental hygiene and public welfare."

MAURICE LORR, Ph.D. Dr. Lorr is a clinical psychologist on the central office staff of the Veterans Administration, division of psychiatry and neurology, at Washington, D. C. He is lecturer and research consultant for the psychology and psychiatry department of Catholic University. He received his Ph.D. from the University of Chicago in 1943 and is a diplomate in clinical psychology of the American Board of Examiners in Professional Psychology.

RALPH KAHANA, M. D. Dr. Kahana is a graduate of New York Medical College in 1946. He interned at Metropolitan Hospital, Welfare Island, New York City. Following internship, he entered the army, spending five months at Brook Army Medical Center in San Antonio, Texas, and about 18 months in the mental hygiene clinic, Fort Knox, Ky. Since 1949, he has had two years of residency training at the University of Cincinnati College of Medicine and is at present a fellow in psychiatry at Cincinnati.

IRVIN HYMAN WEILAND, M. D. Dr. Weiland is a graduate of the University of Cincinnati College of Medicine in 1945. His psychiatric training was obtained at Cincinnati General Hospital and the Cincinnati Child Guidance Home. Following two years residency and two years fellowship, six months was spent as instructor in child psychiatry at the University of Cincinnati. His current appointment is instructor in child psychiatry at the University of Washington, Seattle.

BENSON SNYDER, M. D. Dr. Snyder was graduated from New York University College of Medicine in 1947. After interning at Billings Hospital in Chicago, he began psychiatric training at the University of Cincinnati College of Medicine in 1949. Since January 1951, he has been with the air force, in charge of the psychiatric service at Westover Field, Mass.

MILTON ROSENBAUM, M. D. Dr. Rosenbaum was graduated from the University of Cincinnati College of Medicine in 1934. He received his psychiatric and neurological training at Boston City Hospital, McLean Hospital, and Massachusetts General Hospital. He had his psychoanalytic training at the Chicago Psychoanalytic Institute. He is a member of the American Psychoanalytic Association, the American Neurological Association, and a fellow of the American Psychiatric Association. He is professor of psychiatry at the University of Cincinnati College of Medicine, associate director of the department of psychiatry at Cincinnati General Hospital and director of the department of neuropsychiatry at the Jewish Hospital, Cincinnati.

JOHN F. NEANDER, M. D. Dr. Neander received his degree of M. B. from the University of Minnesota Medical School in 1943 and his M. D. in 1944. He served in the army for two years, and served psychiatric residencies at Grasslands Hospital, Valhalla, N. Y., and at Rockland (N. Y.) State Hospital. He is now a supervising psychiatrist at Rockland, in charge of a treatment unit. Dr. Neander is a diplomate of the American Board of Psychiatry and Neurology, is a member of the American Psychiatric Association and is associate psychiatrist at the Institute for Psychotherapy, New York City.

SAUNDERS P. ALEXANDER, M. D. Dr. Alexander attended Charles University, Prague, Czechoslovakia, and Stefan Batory University, Wilno, Poland, of which latter school he is a graduate. He is at present a senior psychiatrist at Rockland (N. Y.) State Hospital. Dr. Alexander served previously in the Polish Army Medical Corps, and, after coming to this country, served as resident psychiatrist at Rockland, consultant in endocrinology at Rockland, and attending psychiatrist at the Rockland outpatient clinic. He is a member of the American Psychiatric Association.

DONALD L. GERARD, M. D. Dr. Gerard is a graduate of the Long Island College of Medicine, in 1947. He interned at the New York Polyclinic Medical School and Hospital, and obtained psychiatric training at Brooklyn (N. Y.) State Hospital and at Worcester (Mass.) State Hospital. In January 1951, he entered the United States Public Health Service and was assigned from the National Institute of Mental Health to its collaborative research project with the Worcester Foundation for Experimental Biology. There he participated in a multi-disciplined research program investigating adrenal cortical function and the differential reactions to experimental stresses of normal and psychotic men.

In September 1951, he was assigned to the Addiction Research Center of the United States Public Health Service Hospital in Lexington, Ky., to study adolescent opiate addiction. Since July 1952, he has been in New York City continuing this research. In addition to clinical work, Dr. Gerard is especially interested in research dealing with the area where the social sciences and psychiatry overlap. Previous publications by him have appeared in this and other journals.

LESTER G. HOUSTON, M. S. Mr. Houston is consultant on community mental health programs for the Massachusetts Association for Mental Health. Born in Newton, Mass., in 1921, he is a graduate of Howard University, Washington, D. C. He received his graduate degree (M. S. in S. S.) from the Boston University School of Social Work in 1947. For four

years he served the Massachusetts Department of Mental Health as psychiatric social worker; first in the Lowell Child Guidance Clinic, then at the Worcester Psychosomatic Clinic and in the research service of Worcester State Hospital. Mr. Houston was also engaged for a year as community relations secretary of the Boston Urban League. He is a member of the American Association of Psychiatric Social Workers.

STELLA CHESS, M. D. Dr. Chess has been with the Northside Center for Child Development in New York City since 1946, and is now co-ordinating psychiatrist there. A graduate of Smith College, she received her medical degree from New York University in 1939. She served an internship at Montefiore Hospital, served in the psychiatric division of Bellevue Hospital Children's Ward, and served a residency in the psychiatric department at Grasslands Hospital, Valhalla, N. Y. She has completed a course of psychoanalytic training at New York Medical College, as well as a personal analysis, and is now a member of the post-graduate psychoanalytic faculty of New York Medical College.

Formerly resident psychiatrist at Pleasantville Jewish Child Care, she has been in psychiatric work with children since 1941; she has been consulting psychiatrist for the Riverdale Children's Association since 1942. She is an associate in psychiatry and assistant psychiatrist at Flower-Fifth Avenue Hospitals. Dr. Chess is author or co-author of a number of scientific articles dealing with psychiatric and behavior problems in children. She is a member of the American Psychiatric Association, the American Orthopsychiatric Association, the Society of Medical Psychoanalysts and other professional organizations.

KENNETH B. CLARK, Ph.D. Dr. Clark received his bachelor's and master's degree from Howard University, and his Ph.D. from Columbia in 1940. He is associate director and co-ordinator of the psychology department of the Northside Center for Child Development, New York City, a position he has held since 1946; and he is assistant professor of psychology at the College of the City of New York, where he has been on the faculty since 1942. Dr. Clark has taught psychology at Howard University and at Hampton Institute, and has been research psychologist for a number of scientific studies, including service with the O. W. I. on a study of morale in minority groups. He was research psychologist for the American Jewish Congress for two years before assuming his present position at the Northside Center. Dr. Clark is visiting professor on the subject of changing social attitudes at the New School for Social Research, and on the subject of social psychology at the William Alanson White Institute of Psychiatry. In 1950, he served on the fact-finding committee for the Midcentury White House Conference on Children.

He is the author of more than 20 scientific articles, mostly dealing with race and color problems, a number of them particularly concerned with children. Dr. Clark is a member of the American Psychological Association and other professional bodies.

ALEXANDER THOMAS, M. D. Dr. Thomas is a graduate of the College of the City of New York; he received his medical degree from New York University College of Medicine in 1936. He is now a clinical instructor in psychiatry at that institution and is an assistant visiting psychiatrist at Bellevue Hospital. He is a diplomate of the American Board of Psychiatry and Neurology.

EDWARD L. MARGETTS, M. D. Dr. Margetts was graduated from the University of British Columbia in 1941 and received his M. D., C. M., from McGill University in 1944. He is certified in psychiatry by the Royal College of Physicians and Surgeons of Canada, and holds a diploma in psychiatry from McGill. He is in private practice in Montreal, is a lecturer in psychiatry and in the history of medicine at McGill, is honorary librarian of the Allan Memorial Institute of Psychiatry and is assistant psychiatrist at the Royal Victoria Hospital, Montreal. He lists his principal interests as trying to find enough time off from his practice for research in the history of psychiatry, and as promoting interest in the history of psychiatry.

NEWS AND COMMENT

KAREN HORNEY, M. D., PSYCHOANALYST, DIES AT 67

Karen Horney, M. D., psychoanalyst, author and educator, died in New York City on December 4, 1952, after an illness of two and one-half weeks. She was 67 years old.

Born Karen Danielson, in Germany of a Norwegian father and a German mother, Dr. Horney studied at the Universities of Freiburg and Göttingen and was a graduate in medicine of the University of Berlin in 1913; she became a practising psychoanalyst in 1918 and taught at the Institute of Psychoanalysis in Berlin from 1920 until 1932 when she came to this country to become associate director of the Institute for Psychoanalysis in Chicago at the invitation of Dr. Franz Alexander. She remained in the United States and became an American citizen in 1938.

From 1934 until 1941, when she became dean and trustee of the American Institute for Psychoanalysis, a school based on her teachings, she taught at the New York Psychoanalytic Institute. She had practised in New York City since 1934. Dr. Horney developed her own analytic theories and became the founder and leader of an important psychoanalytic group. Her book, *New Ways in Psychoanalysis*, presented some of her theories and techniques. Her other works included *The Neurotic Personality of Our Time*, *Self-Analysis*, *Our Inner Conflicts*, and *Neurosis and Human Growth*.

Dr. Horney had planned a medical career from childhood, when she was impressed by a man she later described as a "nice country doctor." During her career in Berlin, she became widely known internationally and was a participant in the discussion on lay analysis conducted by Freud. She had an early background of travel, having taken voyages with her sea captain father when she was a child. She was devoted to painting as a hobby, and the walls of her apartment were decorated with her own landscapes. Dr. Horney was married to Oscar Horney of Berlin while she was still a medical student. She leaves three daughters, one in New York, one in Washington, and one in Mexico City.

PSYCHOSOMATIC SOCIETY FORUM DATES ANNOUNCED

The American Psychosomatic Society has announced the holding of two New York City psychosomatic forums on February 3 and March 11, 1953. Attendance is open to all interested persons. Paul H. Hoch, M. D., of the New York State Psychiatric Institute will be chairman for the February 3 forum, which will be conducted at 8:30 p. m. in the Blumenthal Auditorium of Mt. Sinai Hospital.

NEW YORK REPORTS 27 NEW MENTAL HEALTH FACILITIES

Establishment in the last three years of 27 new local mental health facilities in New York State has been announced in a progress report to the governor and legislature by the New York State Mental Health Commission. In addition to the setting up of these facilities with state financial aid and advisory service, the commission reports educational activities including the providing of tuition for 247 staff members of the New York State Department of Mental Hygiene who have taken professional training courses on their own time, and the granting of 150 scholarships for persons in the disciplines allied to medicine.

Six research projects are reported, many of them dealing with the mental health problems of an increasingly older population; and during the present year, 29 social agencies are receiving a total of $220,000 in funds through the commission. A current special project deals with the problem of alcoholism, with the co-operation of the New York State Department of Health as well as the Department of Mental Hygiene. State grants to two community clinics for chronic alcoholics have been announced. The mental health commission is comprised of the heads of five state departments, with Commissioner Newton Bigelow, M. D., of the Department of Mental Hygiene as chairman.

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FORM FOR OUT-PATIENT CLINIC REPORTS DRAFTED

The National Institute of Mental Health, in consultation with interested organizations, announces the development of a preliminary report form for collection of nation-wide statistical data in the field of out-patient psychiatric clinics where such figures are not now available. Plans call for the distribution of forms and instructions early this year, with the first nation-wide report to be compiled in 1954. Preliminary drafts of the proposed form have already been distributed to state authorities and national organizations concerned; and the institute is awaiting comments and suggestions before making the final draft. Interested groups who have not received copies of the preliminary form may obtain them on request from the institute.

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DR. GREGORY RETIRES; DR. RODGERS NEW DIRECTOR

Dr. Hugh S. Gregory, director of Binghamton (N. Y.) State Hospital since 1942, retired on January 1, 1953 after 40 years in the state service. Dr. Arthur C. Rodgers, assistant director of Creedmoor State Hospital, was named director of Binghamton to succeed him. Biographical notes on Dr. Gregory and Dr. Rodgers will appear, as is customary, in THE PSYCHIATRIC QUARTERLY SUPPLEMENT (Part 1, 1953).

DR. MARCUS A. CURRY, FORMER GREYSTONE PARK HEAD, DIES

Dr. Marcus A. Curry, former medical superintendent of New Jersey State Hospital at Greystone Park, died at that hospital on November 11 after a brief illness. He was 74 years old. Dr. Curry, a graduate of Albany Medical College in 1904, engaged in private institutional work following his internship before joining the staff of Central Islip (N. Y.) State Hospital. He left Central Islip in 1909 for Greystone. He had been in the New Jersey state hospital service for 41 years when he retired in 1950.

Dr. Curry was a life member of the American Psychiatric Association and was active in both professional and other organizations. As head of Greystone Park, he was one of the principal participants in the widely-known Columbia University-Greystone Park research project in topectomy, in which professional staff members of the New York State Department of Mental Hygiene also participated. Dr. Curry was credited with many advances in New Jersey institutional practice, including the provision of greater freedom for mental patients, the encouragement of recreational and occupational therapy and the establishment at Greystone Park of a pioneer school of nursing.

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JOSEPH H. GLOBUS, M. D., DIES AT 66

Dr. Joseph H. Globus, internationally known for his work in neuropathology, neuroanatomy and neurology, died of a coronary thrombosis at his home in New York City on November 20, 1952. A co-worker with Harvey Cushing, Bernard Sachs and others, he was regarded as one of the founders of the modern American school of neuropathology. Born in Russia, he came to this country as a boy, was graduated from Columbia University, and received his medical degree from Cornell in 1917. He interned at Montefiore Hospital, New York City, and at Manhattan (N. Y.) State Hospital, and did post-graduate work in Germany.

Dr. Globus taught at Columbia, Cornell and New York University, and was author of the text, *Practical Neuroanatomy*, and many scientific articles. He was editor of *The Journal of Neuropathology* and *Experimental Neurology* and of *The Journal of the Mount Sinai Hospital*. He was a former president of the American Neuropathological Society and was an active member of other professional organizations. He is survived by his widow, two sons and a daughter.

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DR. BABCOCK NAMED HEAD OF BUTLER HOSPITAL

Henry H. Babcock, M. D., acting superintendent and physician-in-chief since May 1951 of Butler Hospital, Providence, R. I., has been named permanently to that post by the board of trustees of the institution.

CHILD GUIDANCE PSYCHIATRY FELLOWSHIPS ANNOUNCED

Availability of a number of fellowships offering specialized training in child psychiatry is announced by the American Association of Psyatric Clinics for Children. The training is in specialization for child psychiatry, particularly for work in community clinics for out-patient treatment. It begins at third-year post-graduate level; and minimum prerequisites include graduation from an approved medical school, approved internship and a two-year residency in psychiatry. The majority of the stipends are provided by the United States Public Health Service and are about $3,600 annually, although stipends may be paid from other sources or supplemented by work in addition to the training program.

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HARRIET BABCOCK, Ph.D., PSYCHOLOGIST, DIES AT 75

Harriet Babcock, Ph.D., clinical and research psychologist and author of a number of widely-known books on her specialty, died in New York Hospital on December 17, 1952 after a long illness. She was 75 years old. Dr. Babcock was the widow of H. Hobart Babcock. She taught in the Rhode Island schools for some years before going to Columbia where she received her B. S. in psychology in 1922, her M. A. in 1923, and her Ph.D. in 1930.

In psychological research, Dr. Babcock specialized in clinical work in the efficiency phase of mental functioning, a phase to which she had devoted her efforts since 1931. Earlier Dr. Babcock had served as psychologist for Manhattan (N. Y.) State Hospital and chief psychologist for Bellevue. She was the author of *Time and the Mind* and other psychological books and scientific articles.

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L. S. U. ANNOUNCES PSYCHOLOGIST-TRAINING PROGRAM

Louisiana State University has announced a four-year training program for clinical psychologists, leading to a Ph.D. degree, in an educational effort described as unique in the south. The program, carried out by co-operation of the College of Arts and Sciences and the School of Medicine, is designed to train clinical psychologists for Louisiana state institutions and other institutions in the south.

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UNIVERSITY HONORS NIEDERLAND

William D. Niederland, M. D., of New York City has received the 1952 annual achievement medal of the University of Tampa "in recognition of achievements in intercultural education, intergroup-understanding and mental health." Dr. Niederland was professor of psychology at Tampa in 1946-1947.

GROUP DEVELOPMENT SESSIONS SET FOR JUNE AND JULY

The National Training Laboratory in Group Development will conduct its annual three-week session from June 21 through July 11, 1953 at Gould Academy, Bethel, Me. About 110 applicants will be accepted for the session, and persons involved in problems of working with groups in training, consultant and leadership capacity in any field may apply. The annual laboratory sessions are sponsored by the division of adult education service of the National Education Association and by the University of Michigan. Group skills of analysis and leadership are practised in role-playing and observer techniques. Application of the laboratory work to jobs at home is discussed during the last week of the session.

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RICHARD H. HUNGERFORD, *Editor*

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